RESILIENCE AND PARENTAL ACCEPTANCE AS DETERMINANTS OF SENSE OF WELL-BEING AMONGST DISABLED

ABSTRACT

THESIS

SUBMITTED FOR THE AWARD OF THE DEGREE OF

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IN

PSYCHOLOGY

BY

SAHAR SAEED

Under the Supervision of

PROF. (MRS.) HAMIDA AHMAD

DEPARTMENT OF PSYCHOLOGY
ALIGARH MUSLIM UNIVERSITY
ALIGARH (INDIA)

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ABSTRACT

One of the greatest contribution of psychology in recent times is the emergence of "Positive Psychology" or psychology of strengths, the focus of which is to understand those individuals who experience deep happiness, wisdom, resilience and well-being and to help others develop these capacities in themselves.

The present research aims to explore resilience and parental acceptance as determinants of sense of well-being amongst disabled. Sense of well-being is an important objective of human existence, and many factors contribute to it. For the disabled, who are faced with additional problems and challenges, it becomes a matter of even greater concern. The topic of our study is, therefore, "Resilience and parental acceptance as determinants of sense of well-being amongst disabled". The major objective of the research is to study whether resilience and parental acceptance contribute to well-being.

Resilience is a broad term and various studies conducted on resilience have expounded certain factors which comprise resilience. Therefore the researcher had studied resilience both as a single factor and six specific factors comprising resilience. Further, two other psychosocial factors, age and gender, were taken into account. Therefore the total number of factors studied by the researcher in the context of their contribution to well being were ten.

Since no appropriate tool to measure resilience was available, therefore the first task before the researcher was to develop a scale to measure resilience. The rational-theoretical method together with the factor analytic method was used by the researcher for the construction of the scale.

The researcher, with the help of empirical studies and literature search prepared a comprehensive picture of the concept of resilience. Six factors appeared to be important in this regard. A pool of items reflecting each of the factors defining resilience was created with the help of the teachers and senior research scholars of the department. Experts scrutinized these questions very minutely to ensure that they were unambiguous and clear, that is all the subjects get the same meaning of the statements, which is one of the fundamental assumptions of rational theoretical approach, in fact of all approaches. The screening and rewording of items helped to establish the face validity. It has been pointed out by Kelly (1969) and Hasan (1997) that more than one approach to scale development may be needed for constructing a good scale. Therefore, item homogeneity of the scale was established with the help of factor analytic method (principal component analysis). Six factors, which emerged were given appropriate subtitles, after face validity confirmed that they measure a particular kind of psychological attribute. The six factors which have been studied by the researcher are (i) self esteem, (ii) self efficacy, (iii) perseverance and tenacity, (iv) perception of social acceptability, (v) optimism and (vi) spirituality.

Briefly stated, **self-esteem**, is the degree to which the self is perceived positively or negatively; that is one's overall attitude towards the self. **Self-efficacy** may be defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives (Bandura, 1986). It refers to one's belief about one's own abilities and capabilities. **Perseverance and tenacity**, is the steady persistence in course

of action, in spite of difficulties, obstacles and discouragement. It is regularly used in the favourable sense. **Perception of social acceptability** – refers to the extent to which a person perceives that he/she is accepted by others. In other words to what extent he/she has qualities which make him acceptable to others. **Optimism** is defined as a generalized expectancy that one will experience good outcomes in life. A disposition to believe in favourable rather than unfavourable outcomes to problems. The term **spirituality** is generally used to denote certain positive inner qualities, and perceptions. It does not include narrow, dogmatic beliefs and obligatory religious observances. It is a unified quality of mind, heart and soul and refers to feelings, thoughts, experience and behaviours that arise form a search for the sacred.

After following all the steps diligently, the resilience scale was developed. The Cronbach alpha reliability was found to be .816 and Guttman split half reliability is .804.

With the help of the Resilience scale constructed by the researcher, resilience and its six component factors were studied. Sense of well-being was measured by PGI Well-Being Scale, developed by Verma et al. (1986). Parental acceptance was measured by Parental Acceptance Scale developed by Ansari (1975).

A sample of 200 orthopaedically disabled subjects (100 males and 100 females) participated in our study. Subjects were drawn through purposive sampling. The age range of subject was 8 years to 16 years.

Two groups (high scoring and low scoring) were formed in terms of each variable under study and with the help of t-test, significance of difference between the two groups on the dependent variable, were studied. Since the criteria on which the two groups were identified was a psychological variable (e.g. resilience, parental acceptance etc.) the kind of difference that emerges from the t-test may be deemed to be a relationship (Field, 2000). Therefore, the design, though predominantly a two group design, has characteristics of correlational design also.

The statistical analysis used in the present research was (i) t-test, (ii) 95% confidence interval of the mean differences, (iii) factor analysis (principal component analysis), computation of which involves Kaiser-Meyer-Olkin (KMO) measure and Bartlett's test of sphericity. The statistical analyses was conducted with the help of SPSS 11 software.

Resilience and parental acceptance, gender, age were factors selected for study. Resilience was studied both as a single factor and also in terms of six component factors, namely self-esteem, self efficacy, perseverance and tenacity, perception of social acceptability, optimism and spirituality, bring total factors to ten.

Resilience as a single composite factor was not found to contribute to well-being amongst the orthopaedically disabled. Disabled subjects high on resilience and low on resilience did not differ on their mean scores on resilience.

However three component factors of resilience were found to contribute significantly to the experience of well-being amongst the disabled. Disabled subjects high on self-efficacy, were experiencing significantly greater sense of well being than subjects low on self efficacy. This finding was predicted in the population also.

Perception of social acceptability is another factor that was found to contribute to feelings of well-being in the disabled sample. The sample consists of orthopaedically disabled subjects. The physical self is an important aspect of an individuals self-image. Being genuinely accepted within the group is a factor, which has a very special meaning for the disabled. Therefore those perceiving themselves as socially accepted experience greater well-being than those low on perception of social acceptability.

The third factor which was found a significant predictor of well-being amongst the orthopedically disabled was optimism. Optimism and hope is an important quality for the disabled. Those who possess this quality are manifesting the will to transcend odds that may occur and have high hopes for the future. This positive quality endows them with the experience of well-being. It is strongly felt that resilience should be taken as a broad theoretical framework with significant implications for positive psychology, but the various factors which comprise it should be the focus of research.

Parental acceptance emerged as a significant predictor of well-being for the disabled. Analysis of the mean difference revealed that the phenomena would be found in the population also. Parents perhaps are one of the basic

sources which provide experiences leading to feelings of well-being. Accepting behaviour of parents gives a child warmth, affection, approval, security, and understanding. A child needs a reasonable degree of acceptance in order to lead a healthy, happy and a decent life.

Gender and age are the other two variables which were studied by the researcher. Amongst the disabled, women were significantly lower on well-being than men. The orthopaedically disabled girls constitute a group that experience many major problems. The disturbed picture of the future is one big problem. Therefore it is not surprising that in terms of well-being, she is in a poorer position than males.

Different age groups of disabled also have shown difference in terms of well-being. The subjects falling in low age group experience greater level of well-being than subjects falling in high age group.

Thus the overall picture suggests that well-being is a dynamic phenomena with different factors contributing to it. Resilience as a single factor may not contribute to well-being, but its component factors, with varying degrees contribute to well-being. Parental acceptance emerged as a strong predictor of well-being. In the non-disabled sample, resilience, self-esteem, perseverance and tenacity are found to be significant predictors of well-being.

It must be noted that researchers, psychologists, and people working in the area of disability, must focus on resilience enhancing strategies, and create more awareness about disability in the general population and particularly amongst the parents of disabled.

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DEPARTMENT OF PSYCHOLOGY
ALIGARH MUSLIM UNIVERSITY
ALIGARH-202 002 (U P) INDIA
PHONES Internal Off - 1580 158

Dated .....

Certificate

This is to certify that **Ms. Sahar Saeed** has carried out her research entitled **"Resilience and Parental Acceptance as Determinants of Sense of Well-Being Amongst Disabled"** under my supervision.

It is further certified that her work is an original piece of work and is fit for submission for the award of Ph.D. degree in Psychology.

Hamida Ahmad

Prof. (Mrs.) Hamida Ahmad
Supervisor 16.5.2008

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Sahar Saeed

(SAHAR SAEED)

16.05.08

CONTENTS

Chapter I

INTRODUCTION

For years psychology has focused on repairing damage and curing mental illness rather than helping people develop the strengths and capacities necessary to thrive. One of the greatest contribution of psychology in recent times has been the emergence of "positive psychology" or "psychology of strengths" christened by Seligman in 1988. Its focus is to understand those individuals who experience deep happiness, wisdom, resilience, and psychological, physical and social well-being, and to help others develop those capacities in themselves. The capacities that allow people to thrive are the same strengths that buffer against stress and prevent both mental and physical illness. In addition, Seligman argues that building strengths in clients is the most "potent weapon in the arsenal of therapy".

Positive psychology, however is not a new field. During the times of Socrates, Plato, Aristotle, philosophical and religious inquiry focused on "Good Life". The Humanistic psychologists in 1960's and 1970's focused on the goals for which people strive, their awareness of striving and importance of rational choice, in this process. Research in 1980's and 1990's addressed concepts such as values, well-being, self-efficacy, resilience, coping, strength hardiness etc. Thus like most concepts relating to human nature, what the proponents of positive psychology researched and expounded had not been invented by them. It already existed but by placing it within a fresh and more meaningful framework, a new approach which is optimistic, solution oriented, intellectually appealing came into being.

Achieving well being is an important goal of human existence. In a complex competitive society, it is a difficult proposition, but for those who are

disabled and suffering from various deficits, it becomes all the more challenging. It is an important concern of all societies committed to human values, to help the disabled group to achieve to the optimal level in aspects like self-sufficiency, vocational avenues and quality of life. Perception of well-being is indicative of a good quality of life. Social scientist also have joined this endeavour of exploring factors and situations which can help the disabled group to achieve a meaningful existence.

Disability has been an integral part of human experience as far back as human consciousness goes. Man has always had to deal with disability and come to terms with it, either as a sufferer, a family member or a fellow community member of a disabled person.

Disability is any restriction or deficit, resulting from an impairment, that is loss or abnormality of psychological or anatomical structure or function. This results in a poorer ability to perform an activity in the manner or range considered normal for a human being.

WELL BEING :

Well being is one of the most important goals which individuals as well as societies strive for. Psychological well-being is based on personal growth, self acceptance, environmental mastery, positive relationships, self-determination and a sense of purpose in life. Well being is most commonly used to denote that something is in good for a person. It does not specify what the something is and what is meant by good. Well being can be specified in two ways, first by specifying the what and secondly by spelling out the criteria of wellness (Veenhoven, 2001). However, it is very difficult to precisely bring out a neat definition of the concept of well-being. Popular use of the term well

being' usually relates to health. The philosophical use is broader, but related, and amounts to the notion of how well a person's life is going for that person. A person's well-being is what is good for them. Health, then might be said to be a constituent of well-being, but not plausibly taken to be all that matters for 'my well-being'.

Different terms such as happiness, satisfaction, morale and positive affect etc has been used in literature synonymously with well-being (Chekola, 1975; Culberson, 1977; Jones, 1953, Tatarkiewiez, 1976; Wessmans 1957; and Wilson, 1960).

Bradburn (1969), describes well being as a preponderance of positive affect over negative affect. Current pleasant emotional experiences are thought to be important, or the person is predisposed to such emotions, whether or not he is experiencing them currently. In other words well-being is the amount of positive and negative affect experienced by an individual. However, he founded that these affects are not co-related, rather positive and negative dimensions were related to quite a different set of variables. The positive affect was associated with higher level, social contact and more exposure to new experience. Conversely, various indices of anxiety, fear of nervous break down, physical symptoms of illness etc, were found to be associated with negative affect. These findings of Bredburn have to been broadly confirmed by several research studies carried out in USA and UK (Costa & Macrace, 1980; Bryant & Veroff, 1982).

Levi (1987), defined well being to be a dynamic state of mind, qualified by a reasonable amount of harmony between person's abilities, needs, expectations, circumstantial demands and opportunities.

Diener & Diener (1995) opined that psychological well-being is comprised of person's evaluative reactions to his/her life. These reactions/responses can be both cognitive evaluations and emotional reactions.

Verma, Mahajan and Verma (1989), defined well-being as subjective feelings of contentment, happiness, satisfaction with life experiences and one's role in the world or work, sense of achievement, utility, belongingness with no distress, dissatisfaction and worry.

Most of the scholars, however, see well-being as a combination of the components like happiness, satisfaction, hope, optimism, proper perception of means and ends, faith in absolute truth, values, standards and potentiality for achievement. Well-being includes objective well being, subjective well-being, quality of life satisfaction, and happiness. Lu, L. (1995), Veenhoven (1991) stated that the satisfaction of an individual, after his judgement of his over all quality of life indicates his well-being.

Kozma and Stones (1978) undertook extensive review on the literature related to psychological well-being (1956-1977). In their findings they reported that psychologists have employed multidimensional approaches to the construct of 'well-being' in the western societies. They found that one of the major research issues faced by psychologists was diversity in the very conceptualization of well-being. They found that different experimental procedures were employed to bring out the relationship between three types of well being; affect, strain and satisfaction. He advocated that all three types were intimately interlinked to one another. However, he did not go in far further theoretical classification in this regard. He wisely kept them as separate dimensions rather than to combine them into overall index.

Well-being can be represented into two forms such as objective well-being and subjective well being. Objective well-being deals with the feeling of the 'well off' character that is, the satisfaction one attains after having comforts like good housing, stable financial status, employment etc. The subjective well-being on the other hand, is the ability to maintain balance between one's needs and the environmental demands. It is the congruence between the individual and group expectations and the perceived reality. Bradburn (1969), Campbell (1976), Warr (1978) and others have defined well-being as peoples feelings about their life activities. Such feelings fall on the continuum of negative mental states (anxiety, depression, unhappiness, dissatisfaction, happiness etc.), with the second end indicating well-being. Most of the time it has been observed that an increase in the objective standards of living can enhance one's subjective well-being.

The third generation of research on subjective well-being, focused on health and human development, as the presence of well-being (i.e. health), and not merely absence of illness, disease, and developmental deficiencies, Keyes (2006). Well-being is much more than just an absence of disease. Jahoda (1958), and Berg (1975) suggested that health is not merely absence of illness, rather it is physical, social, mental and spiritual well-being, a state which has been identified as an attribute of positive mental health. This idea was further supported by W.H.O. (1987(F) and Verma et al (1989). It is also the essence of the humanistic model.

Health is generally seen as biological indicator of well-being. An individual's health is well as community health is vital to a good quality of life. World Health Organization (QHO) defines individual and community health as

a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. That is, health not only provides freedom from all illness but also ensures that all physical, mental and social being pervade in that state. Health is a resource of everyday life and an essential part of well-being (Allardt, 1976); not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities (World Health Organization, 1986). Improved physical health and resistance to disease have long term effects on well being. However, in actual reality, the relationship between well-being and absence of disease is very complex. People's perception of their health, illness and causative factors is based on many factors – social, economic, cultural and environmental.

Psychological indicators of well-being, refers explicitly to the subjective perceptions that a person has of their quality of living. This subjective perception was defined as personal development and achievement, self-concept etc. Psychological well-being is therefore represented by the level to which people show sentiments and positive attitude towards various aspects of their lives. Psychological indicators of well-being may be as diverse as mental health; self-concept; feeling of satisfaction and happiness.

Mental health is an easily interpretable and fundamental indicator of well-being. It is a positive sense of well-being in which the individual realize his/her own abilities, can cope with the normal stressors of life, can work productively and fruitfully, and is able to make a contribution to his/her community (World Health Organization, 2004). According to Health Education Authority (1997) "Mental health is the emotional and spiritual resilience which allow us to enjoy life and to survive pain, disappointment and sadness". There

is general agreement that the primary aim of mental health activity is to enhance people's well-being and functioning by focusing on their strengths and resources, reinforcing resilience and enhancing protective external factors (WHO Europe Declaration, 2006).

Broadsky (1988) identified several characteristics of the person who are striving towards well-being. They include a positive affect, substantial satisfaction with life, and a reconciliation of values with realities of society. People make deliberate choices, practices, self-control and take risk to achieve goals. Feeling of control over one's life and circumstances is important for physical and psychological health. There is consensus that sense of control is an indicator of psychological resilience that can facilitate adaptation to change, overcome negative consequences, and promote physical and psychological well-being. Being optimistic in the sense of one's expectation for betterment/improvement in one's life standing is found to be strongly associated with a high sense of well-being. It has impact on one's ways of handling stress, and that affect the way of our cardiovascular, or nervous and immune system work, all of which adds up to great resilience to disease. The level of adjustment is assumed to reflect individual and collective well-being. The successfully adjusted person is pleased with his/her life (Schwarz and Clore, 1983). Maslow (1970); identified the characteristics of the self-actualized person in his humanistic approach. Many of those are characteristics of the happy, well-adjusted person. Everyone would prefer to be well adjusted and happy, but too often people experience so much stress that they are not as happy as they would like to be.

Well-being is an experience which is related to a wide variety of phenomena, situations which enhance meaningful social interactions and give opportunity for close sharing of emotions and ideas foster feelings of well-being.

The sex of the child is one such important factor which determines how people view him and then his/her own view of the world. In most societies gender stereotyping begins in early child and continues through middle childhood and in a very marked way through adolescence. There may be group and individual differences in gender stereotyping but by and large the phenomena is existing in all cultures. A large number of these male-female differences may be explained in terms of different expectancies learned as a part of one's gender role rather than in terms of biology (Major and Adams, 1983) but some differences may be biologically triggered. An overwhelming large number of differences are socially learnt. For e.g. the women's passive role is definitely a cultural product of social pressure to accept second place in assertive aggressive situations and may be the reason, why women are less likely than men to emphasize masculine behavioural styles (Nadkarni, Lundgren and Burlew, 1991). The outcome is that attitude towards male and female child may differ markedly.

In a country like India with male preference strongly embedded in the culture and psyche, gender may become a very important determinant of behaivour. A male child is usually tolerated even if he is aggressive, while female child may be discouraged from being even assertive. Both research work and every day experiences indicate that there are differences between male and females. They have been observed early in development before the

age three in toy and activity preferences (Weinraub, Clemens, Sockloff, Ethridge, Graceby and Myers, 1984).

In certain sections of the society the female child may even be victim of unfair bias in terms of receiving her just share of nourishment etc. the male being considered more important to receive commodities particularly if they exist in deficient amount. It is natural that well being of female is likely to be lesser than well-being of male. However some changes are emerging in the scenario with better education and more awareness, therefore it is a subject which needs to be studied and tested.

Among characteristics which may contribute to helping the disabled group to achieve the maximum potential and maximum happiness, personal resources as well as attitudes of significant others are likely to play an important role in this matter. An important personal resource which has attracted the attention of social scientists is resilience.

RESILIENCE

The post-modern or new science movement tends insights into alternative approaches to therapy and education with directions into helping. The paradigm shift from a reductionistic problem oriented approach to nurturing strengths is a prevalent theme across academic disciplines and the helping professions. In 1970 many social scientists began to probe the question "what accounts for why some people stay healthy and do well in the face of risk and adversity while other's do not?' This perspective is now called "**resilience**" and to date, it has focused primarily on individual health and functioning. Resilience and resiliency have emerged as intriguing areas of enquiry that explore personal and interpersonal strengths that can be accessed

to grow through adversity. Resilience means to spring back to original shape without breaking and bending, or flexibility, or elasticity. Beardslee (1989), succinctly defined resilience as "unusually good adaptation in the face of severe stress". Unusually good adaptation may appear vague, but it conveys effectively the central idea that the quality of resilience facilitates the attainment of a socially desirable and effective state.

Resilience in psychology is the positive capacity of people to cope with stress and catastrophe. It is also used to indicate a characteristic of resistance to future negative events. In this sense "resilience" corresponds to cumulative "protective factors" and is used in opposition to cumulative "risk factors". The phrase "risk and resilience" in this area of study is quite common. Commonly used terms, which are essentially synonymous within psychology are "resilience", "psychological resilience", "emotional resilience", "hardiness" and "resourcefulness".

Ryff, Singer, Dienberglove and Essex (1998) described resilience as an individual's capacity for maintenance, recovery or improvement in mental health following life challenges. Resilience for Lifton (1993) is an individual's capacity for transformation and change.

Morrison, Robertson, Laurie and Keley (2002) describe resilience as a trajectory which is dynamic, not static. Morrison suggests that resilience is a complex entity, residing along a continuum, and emphasizes that resilience should be studied from subjects' perspectives, not form the perspectives of researchers.

Resilience is a two-dimensional construct concerning the exposure of adversity and the positive adjustment outcomes of that adversity (Luthar &

Cicchetti, 2000). Adversity refers to any risks associated with negative life conditions that are statistically related to adjustment difficulties, such as poverty, children of schizophrenic mothers or experience of 9/11 attacks, tsunami 2004. Positive adaptation on the other hand, is considered in a demonstration of manifested behaviour on social competence or success of meeting any particular tasks at a specific life stage, such as the absence of psychiatric distress after the September 11th attacks on the United States (Luthar and Cicchetti, 2000).

The fascination with resilience undoubtedly stems from comparing it with risk. That is, individuals who are regarded as being resilient are considered so because they are not succumbing to what are generally regarded as risk factors (Fraser, 1997) and some children present the "puzzling problem" of prevailing over great adversity (Fraser 1997). However, professionals have not reached consensus in defining or describing just what is meant when using the term resilience.

Some use the term to describe simply the absence of psychopathology or of maladaptive behaviour in high risk situations where psychopathology or such behaviour would have been anticipated (Luthar and Zigler 1991). Garmezy (1993) prefers the term resilient to other possible terms such as "invulnerable", for resilience means to spring back", and "the central element in... resilience lies in the power of recovery and the ability to return once again to... patterns of adaptation and competence". Each of these definitions however connotes the wonder and the surprise – of achievement "against the odd" (Werner and Smith, 1982).

Researchers and those working with disabled people have realized that despite their disability, many disabled individuals are able to cope and live a happy life. What is this 'factor' which is helping them in their survival. In many cases resilience is the answer.

Resiliency inquiry did not emerged from academic grounding in theory, but rather through a phenomenological identification of characteristics of survivors, mostly young people, living in high risk situations.

Resilience emerged as a major theoretical and research topic from the studies of children of schizophrenic mothers in the 1980's (Luthar, Cicchetti & Becker, 2000; Masten, Best, and Garmezy, 1990). In Masten's (1989) study, the results showed that children with a schizophrenic parent may not obtain comforting caregiving compared to children with healthy parents, and such situation had an impact on children's development. However some children of ill parents thrived well and were competent in academic achievement, and therefore led researchers make efforts to understand such responses to adversity. In the onset of the research on resilience, researchers have been devoted to discovering the protective factors that explain people's adaptation to adverse condition such as maltreatment (Cicchetti & Rogosch, 1997), catastrophic life events (Fedrickson, Tugada, Waugh, & Larkin, 2003) or urban poverty (Luthar, 1999). The focus of empirical work then has been shifted to understand the underlying protective processes. Research endeavour to uncover how some factors (e.g., family) may contribute to positive outcomes (Luthar, 1999).

From the historical point of view, the first wave of resiliency inquiry focus on the paradigm shift from looking at the risk factors that led to

psychosocial problems to the identification of strengths of an individual (Benson, 1997). The character, trait, or situational premise of resiliency is that people possess selective strengths or assets, to help them survive in adversity. These resilient characteristics have been referred to as positive factors or developmental assets.

The fundamental study cited in most of resiliency literature was a venture accomplished by Emmy Werner (1982) and her colleague R. Smith (Werner & Smith, 1992). Emmy Werner was perhaps one of the first scientists to use the term resilience. In her longitudinal study of 700, approximately 200 were at risk because of perinatal stress, poverty, daily instability, and serious parental mental health problems. Werner found that 72 of 200 children were doing very well despite the risk factors. Werner characterized the resilient qualities that helped these young people to be competent in the face of high risk environments. Her phenomenology included personal characteristics such as being female, robust, socially responsible, adaptable, tolerant, achievement oriented, a good communicator, and having good self-esteem. She also noted that care giving environment both inside and outside family helped young people thrive in the face of adversity.

Some of the resilient qualities identified by Michael Rutter (1979, 1985) were easy temperament, being female, a positive school climate, self mastery, self-efficacy, planning skills and a warm, close, personal relationship with an adult.

Garmezy (1991) and Garmezy, Masten & Tellegen (1984) found in their Minnesota Risk Research Project, which investigated intentional and informational processing dysfunction in children of schizophrenic parents, that

most children did not become maladaptive adults, but grew up to be warm and competent people. Garmezy's criteria for 'confident' were effectiveness (work, play, and love), high expectancies, positive outlook, self-esteem, internal locus of control, self-discipline, good problem-solving skills, critical thinking skills and humor. Gramezy's triad of resiliency included the personality disposition, a supportive family environment, and an external support system.

The various resilient qualities identified in the field of positive psychology (Seligman and Csikszentmihalyi, 2000), happiness (Buss, 2000), subjective well being (Diener, 2000), optimism (Peterson, 2000), faith (Myers, 2000), excellence (Lubinski & Benbow, 2000), wisdom (Baltes and Standinger, 2000), self-determination (Ryan & Decci, 2000; Schwartz, 2000), creativity (Simmonton, 2000). The other resilient qualities are morality and self-control (Baumeister & Exline, 2000), gratitude (Emmon & Gumpler, 20000), forgiveness (McCullough, 2000), dreams (Snyder & McCullough, 2000), hope (Snyder, 2000), and humility (Tangney, 2000).

The invaluable contribution of the first wave of resilience inquiry helped identify resilient qualities that help people recover from adversity. This paradigm shift from identification of risk factors to the nurturing of personal strengths has been a significant contribution of positive psychology.

The second wave of resiliency enquiry was a pursuit to discover the process of attaining the identified resilient qualities. Flach (1988, 1997) suggested that resilient qualities are attained through a law of disruption and reintegration. Resiliency then became defined as the process of coping with adversity, change or opportunity in a manner that results in the identification, fortification, and enrichment of resilient qualities, or protective factors.

The third wave of resiliency inquiry resulted in the concept of resilience. It become clear that in the process of re-integration from disruption in life, some form of motivational energy was required. That is resilient reintegration requires increased energy to grow, and the source of energy, according to resiliency theory, is a spiritual source or innate resilience.

A succinct statement of resiliency theory is that there is force within everyone that drives them to seek self-actualization, altruism, wisdom and harmony with a spiritual source of strength. This force is resilience, and it has a variety of names depending upon the discipline. Supportive of resilience as a force. Werner and Smith (1992), referred to resilience as an innate "self righting mechanism", and Lifton (1993) identified resilience as the human capacity of all individuals to transform and change – no matter their risks.

In humanistic psychology, resilience refers to an individual's capacity to thrive and fulfill potential despite or perhaps even because of such stressors. Resilient individuals or communities are more inclined to see problems as opportunities for growth. In other words, resilient individuals sum not only to cope well with unusual strains and stressors but actually to experience such challenges as learning and development opportunities.

Whilst some individuals may seem to prove themselves to be more resilient than others, it should be recognized that resilience is a dynamic quality, not permanent capacity. In other words, resilient individuals demonstrate dynamic self-renewal, whereas less resilient individuals find themselves worn down and negatively impacted by life stressors. Some examples of resilient people; Nelson Mendela (jailed for decades in South Africa during apartheid, then later leader of the country), Helen Keller (blind

and deaf from birth), demonstrated remarkable resilience in learning how to communicate and live with people, Anne Frank (Jewish girl who kept famous diary and notes whilst hiding from Nazis, then later died in a concentration camp).

A number of social and ethnic group have been shown to be resilient. Among those are the children of European jews in the United States, the children of the Vietnamese boat people in the United States. Middle class families in times of great depression, children of farmers in times of economical crises, children of Spanish and Vietnamese immigrants in Germany, adoptive children, who went through trauma and malnutrition. The 1980s and 1990s affected children up in rural parts of the state. It was found that great number of children were not affected at all. Most children of farmers grew up to be academically successful and law-abiding. The reasons for this, perhaps, were; strong intergenerational bounds, being socialized into productive roles in work and social leadership, good parenting, a network of positive engagement in church, school, and community life.

Hence, as we think of resilience, it appears that it is totally a within, innate, capacity of an individual. It can be said, that, it depends upon the individual on show he/she takes up him/her self and situation. **Self-esteem, self-efficacy** thus play a vital role in that aspect. Self-esteem is the degree to which the self is perceived positively or negatively; one's overall attitude toward the self. Leary and Baumeister (2000) suggested, that people may need self esteem because it (a) maintains well-being and positive affect; (b) provides feedback about the adequacy of one's coping efforts, (c) reflects an individual's status in a dominance hierarchy; (d) facilitates self-determination, and their

own explanation (e) provides people with vital information about their eligibility for social inclusion and exclusion.

Self-efficacy, another important personality trait which may also contribute to individual's resilience. Self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives, (Banduraa 1986). In other words, one's belief of one's ability to perform specific behaviour. These (self-efficacy) believes determine how people feel, think motivate themselves and behave.

A strong sense of efficacy enhances human accomplishment and personal well-being in many ways. People with high assurance in their capabilities approach difficult tasks as challenges to be mastered rather than as threats to be avoided. Such an efficacious outlook fosters intrinsic interest and deep engrossment in activities. They accept challenging goals and maintain strong commitment to them. They heighten and sustain their efforts in the face of failure. They quickly recover their sense of efficacy after failure or setbacks. They attribute failure to insufficient effort or deficient knowledge and skills which are acquirable. They approach threatening situations with assurance that they can exercise control over them. Such an efficacious outlook produces personal accomplishment, reduces stress and lowers vulnerability to depression.

In contrast people who doubt their capabilities, shy away from difficult tasks which they view as personal threats. They have low aspirations and weak commitment to the goals they choose to pursue. They slacken their efforts and give up quickly in the face of difficulties, and hence fall easy victim to stress

and depression. Thus, self-esteem and self-efficacy, both constitute strong personality traits, and are strong predictors of behaviour.

Perseverance and tenacity is another factor which comprises resilience and which has been taken into account by the researcher. Perseverance may be said to as steady persistence in a course of action, inspite of difficulties, obstacles and discouragement. Perseverance commonly suggests activity maintained inspite of difficulties or steadfast and long continued application. It is regularly used in fvourable sense. Tenacity, steadfastness, doggedness, are used synonymously with perseverance.

Perception of social acceptability is another factor which the researcher has conceptualized to be related to resilience. **Social acceptance** is a term referring to the ability to accept, or to be able to tolerate, differences and diversity in other people or groups of people. The need for social acceptance and approval, it is a very big force in this world. It accounts for a great deal of what people do and why they do it.

Children and adults do a great many tings out of the desire to be accepted by their peers. It is called "peer pressure". They follow latest fads, wear the latest fashion in clothing, cut their hair and many more things are done for the regard, acceptance and approval of others. The level of acceptance or rejection an adolescent experience among their peers influences their trajectory of development. The level of acceptance an adolescence feels will shape his experience in high school and often throughout much of his later life.

Adolescent who are accepted show optimism, about the future and low levels of depression (Allen, Porter, McFarland, Marsh and McElhaney, 2005). These kids often has secure attachments with their families, and their positive

relationships with peers, can be linked to positive relationship in their families. Their competence of understanding the needs of others and themselves is strong and they can manage complex emotional reactions (Allen *et al.*, 2005). Rejected adolescents on the other are shunned, bullied, ostracized and many times abused. The poor treatment they receive from their peers has a severe negative effect on their psychological well-being. Socially rejected adolescence have poor adjustment problems and low self-esteem. They are reported to engage in suicidal behaviours and other criminal or dangerous behaviours (Lev-Wiesel, Nuttman-Schwartz & Sternberg, 2006).

It has been pointed out by researchers, and psychologists that social support gained by making interpersonal connections is associated with health and quality of life, longevity and well being. Devine, Mary Ann, Lashna, Brett (2002) examined the perception of people with disabilities relative to the roles they play in relation to social acceptance and their leisure in experience. Male (3) and female (9) informants (11-35) participated in face to face interview. Three conceptual categories were identified; degree of social acceptance, construction of social acceptance and the leisure experience. Overall data revealed that participants with disabilities, played a role in constructing social acceptance either proactively or reactively, within inclusive leisure contexts. In addition informants identified relationship between constructed acceptance and leisure frequency, friendship development, acceptance of difference and leisure intentions. This study expand upon the understanding of the relationship between social acceptance and leisure experience of people with disabilities by providing insight into their role while engaging in inclusive leisure programmes.

Another important trait which has been related resilience is **optimism**. Scheier and Carver (1985) defined optimism as a generalized expectancy that one will experience good outcomes in life. For Scheier and Carver (1992), optimism leads to persistence in goal-directed striving, and has characterized it as the most powerful predictor of behaviour. It is a disposition to believe in favourable rather than unfavourable outcomes to problems.

Optimism is a psychological resource that gives people a generalized expectancy that they will succeed in their endeavours. It is a belief that future events will have positive outcomes. The beneficial effects of optimism and positive coping skills have been shown to enhance one's ability to deal with stress and depression. On the other hand, studies indicate that being more optimistic and helpful than facts warrant is a sign of pathology (Peterson 2000; Schwartz, 2000; Vaillant 2000). However, Taylor, Reed, Bower and Gruenwald (200) argue that unrealistically optimistic beliefs about future pot protect us from illness. Further according to Salovery, Rotham, Detweiter and Steward (2000) substituting positive emotions for negative ones has preventive and therapeutic effects. Seligman (1998) reported that optimistic people experience less depression and increased enjoyment in social interaction. This is due to their ability to expect positive future outcomes based on positive past experiences.

People who are optimistic will often see more opportunities than those who are pessimistic. They are able to put problems behind them and take a positive view of the future. Optimism is an attitude to life that prevents people from becoming apathetic, or giving up hope.

Another, important factor conjectured to be related to resilience, is spirituality. **Spirituality** is one of the most important sources of strength and direction in people's lives, a human phenomenon, which exists in almost all persons. The term spirituality is generally used to denote certain positive inner qualities and perceptions while avoiding implications of narrow, dogmatic beliefs and obligatory religious observances (Wulff, 1996). Spirituality is a unified quality of mind, heart and soul.

The concept of spiritual health was introduced in 1978 by W.H.O. It is concerned with physical, interpersonal, psychological and mental dimensions of health. Mental health is very important for an individual's effective living. World Health Organisation ((WHO) had defined health as a state of "complete physical, mental and social well-being and not merely absence of disease or infirmity." Mental health is a state of being at peace with oneself and with one's environment. Emotional satisfaction, social adaptability, environmental adaptability and resilience of mind, insight into his/her conduct, harmony between desires and socially approved goals point to mental health.

According to Consensus Document of National Institute of Health Care Research (Hill et al. 1998) spirituality is defined as "feelings, thoughts, experience and behaviours, that arise from a search for the sacred." Spirituality refers to set of beliefs and practices, which directs and influences the behaviours of a person.

Thus, spirituality is that aspect of personality/or one can say is totally one's belief that there exists some force or super-power which helps a person in adversities, and stress. It is the individual's faith, and capacity to view life from a larger and more objective perspective.

Spiritual beliefs constitute an orientation to power greater than life, or awareness of cosmic consciousness, a belief in God and inter connectedness of self to everything in the world. It may be noted that most of the researchers involved in the field have agreed to the fact that spirituality has a broader concept than religion.

Thus, if we look at spirituality, it is a positive capacity which helps individuals in coping with difficult situations and hence, has been related to resilience, the capacity of people to cope with stress and catastrophe.

Ultimately, it seems to the researcher, that resilience is a self renewing process, a dynamic quality that is very private. It is the inner voice that is most prevalent in the human psyche. It is the very nature of life to strive to continue being. When events become overwhelming, when things go wrong, resilience emerges as the capacity to still find the wherewithal, determination and reason to cope with situation, regardless, despite all odds and more often than not, to find ways through. Thus, qualities of resilience contribute to feelings of well being.

PARENTAL ACCEPTANCE

Another factor contributing to positive feelings is possibly parental acceptance because amongst the various systems family support emerges out to be the strongest one. It is this support, which helps us to stand tall even in adversities. Amongst the family, parental support or parental acceptance is the most crucial aspect. A child represents the extension of the parents self and the birth of a disabled child can represent a serious threat to or even damage the parental ego (Kravaceus and Hayes, 1969, Ryckman & Hendeuson, 1965). Dreams are abruptly and slowly shattered. As the moment of initial shock

passes and the parents are able to begin to grasp some of the implications of this event, grief and dismay accompany the realization that the childs disability is permanent. The parent realizes, that all the rest of his or her own life will be colored by the fact of disability.

However, to the new parent, it all seems quite overwhelming. Many will proceed to incorporate this new situation into their lives. They will lower their expectation of the child and enjoy the abilities and accomplishments the child does have. They seek out proper treatment for the child, and provide support and assistance for him/her during the process. Values and goals help the parents. As pain and disappointment become part of life experience for families, new perspectives about which things are important and which are unimportant may emerge. Much human growth is possible as families realize that while life may be different, it is not over. Laughter and joy can again take their place in the family experiences.

Home is the cradle of a child's development. The personality characteristics of the parents would definitely affect the growth and development of the disabled child. The parents who accept their child as deficient may realize the need of consulting a specialist and struggle hard so improve the lot of their child. Parental acceptance is one of the major factors for the well being of their disabled child, parents should learn to accept their children, that would lead them to strive to their utmost, and give the best possible care and training, so that they can make the most of the ability they have. These children require much more time and patience. They will learn and respond to training very slowly, but given a helping hand they will find happiness worth in life.

Parents perhaps are the basic source of well-being of the disabled. He/she should be accepted first by his family, and most importantly by parents then by others. Parents acceptance and positive view gives children with disability encouragement and instills in them a sense of redemption. Love, patience and understanding at home level is most important. Positive and accepting attitude is very important for preventing insecurity in a child with disability. It gives a sense of security, belongingness, love and increases, child's self confidence and self esteem, and makes him competent.

Acceptance, can be developed with reference to the following :

- Acceptance that the child has a handicap.
- Acceptance of the child
- Acceptance of self. The above are major and critical steps in healing and growing process. They imply a recognition of the value of such children for who they are. They are children first and most important of all, they have feelings, wants, and needs like other children. They have the potential to enjoy life and to provide enjoyment for others. They can set for their parents and parent's can set for them, realistic, attainable goals. And the attainment of these goals brings satisfaction, pride and pleasure to parents and children themselves.

As acceptance is one of the basic needs of humans (Maslow, 1954), disabled are not different in this need from anyone else. They need to be accepted as worthy individuals, both by others and from their own personal views. However, the entire process of reaching self-acceptance is a long and difficult one for the parents. It is filled with pain, frustration self-doubt, ego shattering experience. Some how, in spite of all the hurts, and debilitating

experience the parents can emerge with a firm conviction that they are parents of a very special child.

Research has shown that the early months of life are tremendously important in starting the infant on the pathway of healthy or unhealthy development. Particularly significant during this period is "mothering" the subtle factor of maternal love and stimulation (Ribble 1944; Bowlby, 1952; Roudinesco, 1952), Freud described the mother child relationship as anaclitic (literally, leaning on") to denote child's dependence on his or her mother's sustenance (Ainsworth and Bill, 1969). In her capacity to arouse both pleasurable and unpleasurable sensations in the infant, the mother becomes, ... "unique without parallel, established unalterably, for a whole life time as the first and strongest love object, as the prototype of all later love relations for both sexes (Freud, 1949).

The role of mother is of great importance, what happens if she does not supply sufficient security and affection to the infant? A child raised under these conditions becomes insecure, aggressive, demanding, jealous, self centered, and psychological growth is minimized (Sen, 1978, 1988). As an adult, the person will be controlled by childhood motivations and by infantile drives and conflicts, and is likely to develop some form of mental illness

Psychologists on the basis of information gathered through interviews, questionnaires, and ratings of parents and children suggested the importance of two dimensions of parental behaviour, acceptance rejection and permissiveness restrictive ness (Becker, 1964; Martin, 1975; Sears, Maccoby and Lewin, 1957; Symonds 1939). These dimensions have undergone the most intensive examination.

Acceptance-rejection refers to the respect and love or lack of both that parents feel for their children. At the extreme, accepting parents show warmth, affection, approval and understanding. Rejecting parents on the other hand, are cold, disapproving and primitive. They do not enjoy their children nor are they sensitive to their needs.

Schaefer (1959) on the basis of his observations of mothers' interaction with the children from one month to three years of age has arranged maternal behaviours in a circular order around the two dimensions of love and hostility (acceptance-rejection) and autonomy and control (permissiveness restrictiveness). This model indicates a range of parental behaviours and also shows that both permissive and restrictive parents can be either accepting or rejecting. Very different environments are provided for the child, depending on the earnest positions on these dimensions

The impact of close and intimate relationship between the child and his parents has always been emphasized in human societies. The child comes to look upon the parents as the source of all his satisfaction, and as the persons who are to supply all the basic needs that he a child, experiences. At the same time the child may look upon parents as the source of his handicap, which causes hate, sometimes he may perceive the parents as the source of the solution of his disability (Sen, 1988).

A handicapped child, may sense very easily the emotions of his parents. If the parents consider the disability a calamity which has made his life good for nothing, the child would also think likewise. If they feel bitter against an unjust fate, he would also start thinking the same. If the parents make his handicap the pivot of their existence, he is liable to use it with self-centered

motives to extract sympathy from others. However, if they accept his limitations in an objective manner, he is likely to think and act in the same manner (Sen 1988; Freeman, 1973).

On the other hand if the child with disability is poured with excess love, care, protection, and security, he/she may develop a sense of insecurity, helplessness, alienation, frustration, depression and resentment. The family and parents need to encourage the child to attain the social acceptance, self acceptance and independence. He/she has to actualize him/her self, to realize his potentialities. And on the other hand, parents will need to overcome their feelings of frustration, guilt, confusion, despair, contradictions, helplessness and segregation.

The concept of parental acceptance, means that the child is accepted physically, mentally, emotionally and psychologically by his her parents. Whether the child particularly the disabled child, feels happy or unhappy, depends a lot upon his emotional health, and is determined mainly by the environment in which the child grows up and the relationships he/she has with the people in his environment. Love and acceptance helps the child feel secure, happy and confident. The child need a reasonable degree of acceptance in order to lead a healthy happy and decent life (Kelly & Wallerstrain, 1976).

According to Symonds (1989), "accepted children are more cooperative, socialized, friendly, have highly valued personal characteristics and are happier and more stable than the rejected group of children."

Acceptance would not mean passive resignation, rather continuing to struggle and to challenge to find the best possible options for the child and the family. Realistic acceptance acknowledges that "negative" feeling of anger and

sadness are natural and will continue to be felt, although they will assume different proportions, as enthusiasm, hope and joy resume their places in the parents lives. The parents with this kind of acceptance may be far from docile and will help disabled child grow into a stronger, wiser, and more compassionate human being, experiencing positive feelings and a sense of well-being. It appears that resilience and parental acceptance both contribute highly to the experience of well being.

Chapter II

REVIEW OF LITERATURE

All scientific endeavor is part of a concerted effort of academicians and researchers, such that the findings of one research help to pave the way for other researches. Thus, a recapitulation of empirical work conducted in a particular area is extremely important to give proper direction to research.

This facilitates the researcher by presenting the status of knowledge in a particular area, so that the researcher can give thrust to research which maximizes its utility. The opportunity to benefit from vicarious experiences also enriches the methodology and design to be selected by the researcher. In the forthcoming paragraphs, major researches conducted in the field are being presented.

WELL-BEING

Well-being is most commonly used to describe what is ultimately good for a person. Well being is hypothesized by the researcher as a state that is likely to occur if individuals possess resilience and experience parental acceptance are being discussed .

Literature reveals that personality traits and psychological resource (PRs) are important in subjective well being. Lightsey (1996) reviewed the literature regarding four PRS (positive thoughts hardiness, generalized self-efficacy and optimism) and discuss the relationships among PRs and between PRTs and personality characteristics. A process theory that places PRs within the larger context of human functioning is proposed .

Dum (1996), examined the salutary effects of finding positive meaning in a disabling experience with special reference to being an optimist, and

perceiving control over disability on two criterion of psychological well being, namely depression and self-esteem. A main in survey on psychological adjustment to limb amputation was completed by 38 persons, with amputation. Regression analysis revealed that finding meaning following amputation was linked to lower levels of depression symptomatology but not to self-esteem. Both dispositional optimism and perceived control over disability were center for epidemiological studies depression scale and higher scores on Rosenberg's self esteem scale.

Nathawat (1996) examined the effects of gender hardiness and social support, in 100 male and 100 female upper middle class elderly aged 60-70 years retired from government jobs. Male subjects disclosed higher positive affect and life satisfaction than female and scored lower on negative affect and hopelessness. A similar trend of superior well-being was observed in high hardy, aged than low hardy aged, also in aged with high social support than in aged with low social support. Two way interactions of gender hardiness, hardiness – social support and gender-social support influenced some of the measures of well being. The measures were not influenced by 3-way interactions.

According to Diener, Suh, Oishi (1997) subjective well being (SWB) is a field of psychology that attempts to understand people's evaluation of their lives. These evaluations may be primarily cognitive (eg. life satisfaction or marital satisfaction) or may consist of the frequency with which people experience pleasant emotions (eg. joy, as measured by the experience sampling technology) and unpleasant emotion (eg. depression). Researchers, in the field

however, aim to understand not just undesirable clinical states, but also difference between people in positive levels of long-term well-being.

Robitschek and Kashubeck (1999) after examining several mediational models of well being, found that personal growth orientation appeared to mediate fully the relation of family functioning to distress for both genders. For women hardiness appeared to mediate partially the relation of family functioning to well being, for men this relation appeared to be fully mediated by hardiness. The models were predominantly invariant across genders. Parental alcoholism had no direct effects on well being or distress, indirect effects were found through family functions personal growth orientation and hardiness.

Moomal, and Zubair (1999) examine the relationship between meaning in life and mental well-being and states that a sense of meaning in life is an important element in providing coherence to an individual's world-view and hence to his/her mental well being. Correlation analysis of data revealed that meaning in life is associated with a wide spectrum of conventional categories of psychopathology as well with general neurosis.

The relationship between demographics, resilience, life satisfaction, and psychological well-being was examined by Christoper (2000). Findings reveal that number of annual health care appointments, higher resilience and greater life satisfaction were the strongest predictors of psychological well-being.

Yuval Guttman, Koenen, Livinovsky (2001) examined associations among attachment styles hardiness and mental health in intensive real life stress. Secure attachment style was positively associated with over all hardiness commitment and control, where as avoidant and ambivalent attachment styles

were negatively associated with these variables. In addition, a secure attachment style and over all hardiness, commitment were positively associated with mental health and well-being and negatively associated with distress and general psychiatric symptomatology, where as avoidant and ambivalent styles were inversely related to mental health and well-being and positively related to distress and general psychiatric symptomatology. Regression models, testing the relation between attachment, hardiness and mental health suggest that both attachment and hardiness are predictors of mental health in real life stress.

Paradis, Kernis (2002) examined the extent to which self esteem levels and SE stability predicted scores on Ruff's (1989) multidimensional measures of psychological well-being. Results suggests that high self esteem was associated with greater well-being than low S.E. In addition, main effects on SE stability emerged for the autonomy, environmental mastery, and purpose in life subscales, indicating that stable SE was associated with higher scores than was unstable SE. Finally SE levels stability interactions emerged for the self-acceptance, positive relations and personal growth subscales indicating more complex relationship between self esteem and these aspects of well-being.

Scannell, Allen, Burton (2002) examined the relationship between meaning in life and well being, by asking 83 adults (aged 18-84 years) to complete measures of well-being and revised Life Regard Index that contains affective (Fulfillment) and cognitive (Framework) subscales of meaning in life. Although there were no age differences on fulfillment, the younger group had significantly lower score on Framework than the older group. One negative factor (Depression) and two positive factors (happiness, spiritual) significantly predicted framework. Also no negative and 3 positive (happiness, spiritual,

self-esteem) well being measures significantly predicted fulfillment suggesting that affective meaning in life may relate to positive well-being more than it does to negative well-being. On the other hand comparison of two regressions shows that well-being measures were more strongly related to affective meaning (Fulfillment) than to cognitive meaning (Framework). This suggests that although cognitive and affective meaning are associated with person's well being, it is more important to feel that one has meaning in life than to have a structure for that meaning.

According to Ormel, Lidenberg, Stenerink and Verbrugge (1999) two ultimate goals that all human beings seek are optimization of physical well-being and social well being and the five instrumental goals by which they are achieved are, stimulation, comfort, status, behavioural confirmation, affection. The correlation of the approach is that the people choose and substitute instrumental goals so as to optimize the production of their well-being, subject to constraints in available means of production.

DeNeve and Cooper (1998) found personality equally predictive of life satisfaction, happiness and positive effect. The traits most closely related to subjective well-being were repressive-defensiveness, trust, emotional stability, locus of control-chance, desire for control, hardiness, positive affectivity and self-esteem.

In a review of recent cross cultural evidence of happiness and well-being, Uchida, Norasakkunit and Kitayama (2004), identified substantial cultural variations in (1) cultural meaning of happiness, (2) motivations underlying happiness, and (3) predictors of happiness. Specifically, in North American cultural contexts, happiness tends to be defined in terms of personal

achievement. Individuals engaging in these cultures are motivated to maximize the experience of positive affect. Moreover, happiness is best predicted by self-esteem. In contrast, in East Asian cultural contexts, happiness tends to be defined in terms of interpersonal connectedness. Individuals engaging in these cultures are motivated to maintain balance between positive and negative effects. Moreover, happiness is best predicted by perceived embeddedness of self in social relationship.

Caprar and Steca (2005), examined a conceptual model positing that affective and social self regulatory efficacy beliefs influence one's cognitive and affective components of subjective well being, namely positive thinking and happiness. Positive thinking corresponds to the latent dimension underlying life satisfaction, self-esteem, and optimism. Happiness, instead, corresponds to the difference between positive and negative affect, as they are experienced in a variety of daily life situations. The study was conducted on 683 Italian adults belonging to six different age group. The findings of the study corroborated the paths of relations linking the examined variables.

Mechanisms by which personality affects well-being are not well understood. Following recommendations to examine intermediate process variables that may help explain the personality – subjective well-being (SWB) relationship, Harris and Lightsey (2005), tested whether constructive thinking (CT) mediated the relationships between both neuroticism and extroversion and SBW components. Measures of each construct were administered to 147 undergraduate volunteers twice over four weeks. In analysis controlling for time SBW, mood, CT fully mediated the relationship and emerged as a strong predictor of negative affect (inversely), positive affect and happiness.

Given the far-reaching social, economic and demographic changes in the aging population, Greene, Roberta and Cohen, Harriet (2005), argue for the methodological and practice – oriented transformation in future generic social work,. It was suggested that if they are to maintain their independence and well being a resilience enhancing social work intervention will be especially effective in fostering the specific survival skills that older adults, often utilize to help them cope with difficult situations. A risk-resilience model sensitive to ethnic difference and practiced at multiple systems (eg. the community) is offered as an advancement of the traditional models of social work practice. In conclusion, the authors emphasize the value of strengths perspective to address the pressing issues that affect the aging population.

Numerous studies have shown that compared to individuals from intact, biological families, individuals in step-families tend to face worse emotionally, socially, physically, and psychologically. Several studies have attempted to account for the discrepancy, but the research has not yielded definitive results. The study evaluated attachment to parents as a possible explanation for discrepancies in psychological well-being. The results confirmed that attachment was a significant predictors of well-being. Additionally, individuals from step families were found to have less secure attachment to their parents than individuals from intact biological families. It was also found that attachment (operationalized as maternal and parental) are partially mediated the relationship between family type (intact, biological family vs step family) and psychological well-being (Love, 2004).

Parental influence on college student's well-being is underestimated frequently in the developmental literature. College students often set social and

academic goals according to their perception of what their parents expect from them. The discrepancy between college student's performance and their perceptions of parents' expectations can impact their quality of life. Agliata (2006) examine various parent-college student expectation discrepancies and communication level as predictors for college students psychological well-being. Results revealed that college students reported experiencing higher levels of anger, depression, and anxiety and lower levels of self-esteem and college adjustment when higher expectation performance discrepancies were present. Results also indicated that a higher perceived level of communication particularly by the college student, served as a predictor of distress and was related to lower levels affective distress and higher levels of self-esteem and college adjustment. Such findings underscore the importance of teaching assertive communication skills to college students and their parents as a means of diminishing the deterious effects of perceiving one another inaccurately.

Much work address the importance of siblings and friendships in separate investigations, few studies simultaneously examined both relationships. Young adults (N-102, M age 18-7) were surveyed about their friendships, their sibling relationships, and their psychological well being (assessed by self-esteem, loneliness). Participants with harmonious (high warmth, low conflict) sibling relations and same gender trends had low well-being. However participants who had low involved (low warmth, low conflict) and affect intense same-gender friendships did not differ in well-being. When joint effects was examined, having a harmonious same gender friendship compensated for having a low-involved sibling relationship but having harmonious sibling relations did not compensate for having low involved friendships. Overall the results underscore the importance of positive and

negative relationship properties and the joint effects of multiple relationships (Sherman, Lanstord, and Voiling, 2006).

It has been suggested that the mental health of school children can be undermined by repeated bullying at school and further exacerbated by having inadequate social support. Rigby (2000), evaluated effects of peer victimization in schools and perceived social support on adolescent well being. Analysis indicated that both sexes frequent peer victimization and low social support contributed significantly and independently to relatively poor mental health.

Meeus (2003), studied parental and peer support and identity development, and psychological well being in adolescence. The aims of the study were (a) to report on age-related changes in parental and peer support and identity development, and (b) to predict psychological well being by parental and peer support and identity. Study showed that parental support decrease as adolescents grow older while peer support increases. In general peer support catches up with parental support but doesn't take over. Compared to peer support, parental support is the better predictor of psychological well-being, but only in early and middle adolescence. So as regards parental support a separation effect was found. Results also revealed, identity to develop progressively with age, and also the relation between identity status and psychological well-being was fund to become stronger with age. Taking together, these findings support the notion of the second separation individualisation in adolescence.

Sehgal (1990) compared self-efficacy, stress, well-being and health status between male and female college students. Results show that males obtained higher self-efficacy psychosomatic stress scores but no significant difference was found in the well-being scores.

Although marriage continued to promote well-being for both men and women, in some cases autonomy, personal growth the single fared better than married. Marks and Lambert (1998). The effects of continuity in single status were not very different for women in contrast to men. The transition to divorce or widowhood was associated with somewhat more negative effects for women.

In urban India, working women are expected to continue to perform their individual domestic duties, the likely result being compromised well-being due to role strain. Husbands of working women may also experience pressures and hence poorer well-being. Well-being in working couples, particularly husbands, is little researched in developing countries. In one such, type of study Andrade, Portma and Abraham (1999) observed that, in one working as well as both working families, wives experienced more loss of well-being than their husbands. Working wives experienced more confidence in coping than non-working wives. Husbands in both working families experienced better social support but less social contact, less mental mastery, and poorer perceived health than husbands in one working families. Few or no socio-demographic variables were associated with well-being. Results suggest that wives employment benefit women but stress their husbands.

Schonert-Reichl and Kimberly (1994) investigated gender differences in relationship between depressive symtomatology, social class and ecocentrism during adolescence. Females regarded themselves as higher in uniqueness and self-consciousness than males. Social class as measured by father's educational level significantly related to adolescent's egocentrism. Gender differences emerged with respect to relationship between dimensions of adolescent egocentricism and depressive symtomatology.

Street and Kromey (1994) conducted a study to find sex difference in adjustment. Females were found to experience difficulties with self-esteem, depression and anxiety more than males. Males were more likely to experience difficulties with substance abuse.

Gender differences exist in home life also even when both partners are employed in demanding and high paying jobs, work at home is often divided along gender lines, males are more likely to do out door work related to home life while, females are more likely to engage in house cleaning, working and child care. Although females do more work at home than males even if they are doing full time job outside (Gunter and Gunter, 1991).

Emerson, Eric, Hatton and Chris (2008) investigated the association between indicators of subjective well-being, and the personal characteristics, socio-economic position, and social relationships of adults with intellectual disabilities. Variation in subjective well-being was strongly and consistently related to indicators of socio-economic position and to a lesser extent, social relationships. For women being single was associated with greater well being on all indicators. For men, there were no associations between marital status and well-being. Relationships with friends who also had intellectual disabilities appeared to be protective against feeling of helpless.

Research indicates that gender role is a good predictor of psychological adjustment. Masculine and androgymous children (a type of gender role identity in which the person scores high on both masculine and feminine personality characteristics) and adults have a higher sense of self-esteem, whereas feminine individuals often think poorly of themselves (Alpert-Gillis & Connell, 1989; Boldizar, 1991).

The construct of well-being is being constantly refined and has been able to settle as a cordial concept in recent theorization as hedonic psychology (Kahneman, Diener and Schwartz, 1999), positive psychology (Seligman and Csikszentmihalyi, 2000) and health psychology (Suls and Rotham, 2004; Singh et al., 2006). Well-being is a multidimensional construct comprising of physical, mental and social components. Subjective well-being refers to how individuals evaluate their lives, and includes variables such as life satisfaction, joy, absence of depression etc. Research by Diener (1984) on subjective well-being clearly highlights that well-being should be defined in terms of the internal states of the respondent and not through an imposed external frame of reference.

RESILIENCE

Interest in the area of resilience started in the 1970's when many social scientists began to shift their orientation to the question "what accounts for why some people stay healthy and do well in the face of risk and adversity while other do not". This perspective is now called "resilience", and to date, it has focused primarily on individual health and functioning. Egeland, Carlson and Sroufe (1993) examined resilience in 267 high risk children and families. Resilience was conceived not as an inherent capacity, but as a capacity that developed over time in the context of person-environment interactions. It was observed that poverty and maltreatment had a pervasively negative effect on child adaptation. Emotionally responsive care giving mediated the effects of high-risk environments and promoted positive change for children who had experienced poverty, family stress, and maltreatment.

Rutter and Michael (1993), reviewed what is known about relationship of resilience to psychological adversity. Biological studies on resilience to disease or physical hazards show that resilience does not derive from avoidance of risk but from controlled exposure. Evidence from behaviour genetics suggests that in many circumstance non shared environmental influences tend to have a greater effect than shared ones. It is also important to recognize turning points in people's lives whereby those set on a maladaptive life trajectory may turn onto a more adaptive path. Other factors that may influence resilience include experiences, temperament characteristics, how people judge their own circumstances and the influence of protective mechanism.

Fonagy, Steele and Steele (1992) examined the development of resilience against the transgenerational replication of disadvantage through the acquisition of a reflective self function, in the frame work of attachment theory. Data suggest that reflective – self function was most consistent in pinpointing resilient mothers and showed a potential to account for the predictive power of some other protective factors.

Radke-Yarrow (1994), developed standard case studies on 18 resilient children with healthy adaptation throughout development and on 26 troubled children with serious persistent problems. Based on longitudinal data, subjects were compared to controls comprising of well-children and well functioning families. All subjects had family risks of affective illness in both parents and a highly chaotic and disturbed family life. Resilient children were very similar on most measures. Troubled subjects as a group had lower scores on the Weschler Intelligence scale for children, were more often shy, had poor academic achievement, and had a history of poor peer relationships. Resilient subjects

elicited more positive reactions from teachers, were more likely to be favoured child in the family and had more positive self-perceptions. Profiles of each subject showed competing process of vulnerability and coping.

Werner and Emmy (1995), report that several clusters of protective factors have emerged as recurrent themes in the lives of children who overcome great odds. Some protective factors are characteristics of the individuals. Resilient children are engaging to other people, they have good communication and problem solving skills, including the ability to recruit substitute care givers, they have a talent or hobby valued by their elders or peers, and they have faith that their own actions can make a positive difference in their lives. Another factor that enhances resilience in development is having affectional ties that encourage trust, autonomy, and initiative. These ties are often provided by the members of the extended families. There are also support systems in the community that reinforce and reward the competencies of resilient children and provide them with positive role models, caring neighbors, teachers, elders, mentors, youth, workers and peers.

Turner, Norman and Zung (1992), discuss resiliency in girls and boys and gender specific adolescent prevention programs. Resilience is regarded as the ability to cope in the face of adversity. This approach emphasizes on the strengths and the enhancement of individual and environmental protective factors. **Self-esteem and self-efficacy** are most important traits of resiliency. Thus prevention programs should focus on raising self-esteem and self-efficacy in pre-adolescents and adolescents. Evidence indicate that girls and boys pass through developmental stages in different ways and meet dissimilar social cultural and psychological demands. Therefore they need different kinds of

protection, support and encouragement to become adolescents. The field of intervention should design and implement strategies and programs that fit both the similar and unique need for girls and boys.

Wyman, Cower, Work, and Kerly, (1993) examined relationship between children's future expectations and variables reflecting self-esteem functioning with urban children exposed to high psychological risk. Results indicated that future expectations were related to affect regulation, self-representations, and school adjustment. Another study, follow up of 67 subjects showed that early positive expectations predicted enhanced socio-emotional adjustment in school and more internal focus of control, and acted as a affects of high stress on self rated competence. Findings are consistent with data showing positive expectations to be characteristics of resilient children and suggest that early positive future expectations influence later adjustment.

Paterson and Field (1995) examined the relative influence of adolescents' perception of their attachment with their mothers, fathers and friends, on 3 measures of Self-Esteem (SE). Utilization of emotional support and proximity (one of the dimensions of attachment relationship being assessed in the study) with mothers, fathers, and friends was minimally related to overall SE, coping abilities and social competence. The quality of affect, (another dimension of attachment relationship), towards mothers and fathers was significantly related only to social competence. Results suggest that Ss' SE is more strongly associated with quality of affect toward parents and friends than with utilization of these target figures for support or proximity.

Garske and Gregory (1996), examined the attitudes of personal attendants towards persons with severe disabilities, their own self esteem, and the

relationship between these variables. Results showed moderately positive attitudes towards person's with disabilities and positive self-esteem. Self-esteem was positively related to attitudes towards persons with disabilities.

Schutz, (1997), conducted four studies based on questionnaires and autobiographical method in order to compare the self presentation of people with high vs low self esteem. Results show that high self-esteem subjects admit fewer flaws, present themselves positively and justify their behaviour. They also emphasize their competencies, are critical in evaluating others, and tend to compare themselves positively to significant others. Low self-esteem subjects admit wrong doing more readily and emphasize social orientation altruism.

Horwitz, (1998), discusses direct and indirect trauma and personal vulnerability among child protection social workers. Psychological trauma theory (involving stress and burnout) enhances earlier contributions of the stress and burnout literatures in the effort to increase the efficacy and well-being of child protection staff. Resilience theories (e.g. role of self-esteem) are relied on to develop strategies for promoting optimal effectiveness of social workers who remain exposed to potentially traumatizing events.

Brendgen, and Bukowski (1998) examined whether a perceived lack of closeness with parents would be mediated by a lack of self esteem. Results show that self-esteem mediated the relation between perceived closeness with parents.

Greenier, Kernis, McNamara, Waschul et al (1999), examined the extent to which level and stability of self-esteem predicted the impact that everyday positive and negative events had on individuals feelings about themselves. Negative and positive events had a greater impact on the self-feelings of

individuals with unstable as opposed to stable self-esteem (although the effect for positive events was marginal). Negative events had a greater impact on the self-feeling of individuals with low as compared to high levels of self-esteem.

De Mello, (1999), examines self-esteem, locus of control, and coping styles and their relationship to school attitudes of adolescents. Results showed significant correlations between S.E., locus of control, coping styles. Those with high S.E. and internal locus of control scores and were high users of the productive "problem solving", coping styles, showed significantly more positive perception of their academic performance. No gender differences were found in the scores. However, females reported more positive attitude towards school.

Furnham and Cheng (2000) examined, to what extent recalled parental rearing styles (authoritarian, authoritativeness, permissiveness), personality (extraversion, neuroticism, psychoticism, lie), and self esteem predicted self rated happiness in a normal non-clinical population of young people. Regressional and path analysis showed, self-esteem to be the most dominant and powerful predictor of happiness. This finding is reiterated in another study conducted by Cheng & Furnham in 2004 which attempted to determine the relative importance of self-criticism, self-esteem and parenting styles in predicting happiness. Results indicate that self-esteem had the most dominant and powerful correlation with happiness. Maternal care was a significant correlate of both self esteem and self criticism. Maternal care was the only direct correlate of happiness when paternal and maternal rearing styles were examined together suggesting that the warmth showed by mothers their children was particularly beneficial in increasing the offspring's scores on self-reported happiness.

Robins, Tracy, Trzesniewski, Potter (2001) examined the relation between self esteem & Big Five Personality dimensions. The five personality dimensions accounted for 34% of the variance in self-esteem. High self-esteem individuals were emotionally stable, extraverted and conscientious and were somewhat agreeable and open to experience. The relations between self-esteem and Big Five, largely cut across age, sex, social class, ethnicity, and nationality, High self-esteem individuals tended to ascribe socially desirable traits to themselves, and this tendency partially mediated relations between the Big five and self-esteem.

Murray, Rose, Bellania, and Holmes, (2002) examined how needs for acceptance might constrain low versus high self-esteem people's capacity to protect their relationship in the face of difficulties. The authors led participants to believe that their partner perceived a problem in their relationship. The measurement of perception of partners acceptance, partner's enhancement, and closeness, revealed, low but not high self-esteem participants read too much into problems, seeing them as a sign that their partner's affection and commitment might be warning. They then derogated their partner and reduced closeness. However, being less sensitive to rejection, high self-esteem participants affirmed their partners in the face of the threat. Ironically, chronic need for acceptances may result in low self esteem people seeing signs of rejection where none exist, needlessly weakening attachments.

Di Paula and Campbell (2002) examined self-esteem, persistence and rumination in the field of failure. The manipulation of degree of failure and availability of goal alternatives revealed that, when an alternative was available high self esteem (HSE) individuals persisted more than low self esteem (LSE)

participants. after a single failure, but less after repeated failure. When no alternative was available. no self-esteem differences in persistence emerged. Another study examined persistence and rumination for 10 personal goals across an academic year. HSE participants were better calibrated (higher within in subject correlations between perceived process and persistence across goals) had overall levels of persistence. higher grade point averages, and lower levels of rumination than LSE participants. Although traditional views that emphasized the tenacious persistence of HSE individuals need revision, HSE people appear more effective in self regulating goal-directed behaviour.

Yarckeski. Mohan & Yarckeski (2003). examined the relations of social support and self esteem to positive health practices in early adolescents. Results. show a correlation of 0.59 between scores of social support and scores for positive health practices and correlation of 0.44 between scores on Rosenberg self-esteem scale and scores for positive health practices.

Predictors of self-esteem were examined in pre-adolescents and adolescents with cerebral palsy, in a study conducted by Manvel, Balkrishnan Camacho and Smith, (2003). On an average self esteem was high, although 30% scored below cut point for low self-esteem. Self-esteem was bivariately associated with female gender, better physician-assessed functional ability, greater perception of the impact of the disability and higher perceived parent over protectiveness. In a multivariable model, only perceived impact of disability remained significant.

Sysmister's and Friend (2003) focused on the mechanism through which social and problematic support effects psychological adjustment in chronic illness. The authors hypothesized that self esteem would mediate the relations

between social and problematic support and adjustment. Results indicated social support operated through self-esteem, to influence optimism cross-sectionally and prospectively and depression cross sectionally. Social support was also associated with high self-esteem, which in turn increased optimism and was related to decreased depression. Problematic support was unrelated to self-esteem Disaggregating social support into subscales showed that belonging support predicted decreases in depression, both tangible and belonging support predicted increases in optimism.

The two major predictors of subjective quality of life (SQOL) in adults are known to be self-esteem and a sense of primary control. Moreover secondary control is known to be an important defence strategy when primary control fails. Marriage and Cummins (2004) aimed to determine whether these relationships also apply to children. It was found that younger children use more primary control and less secondary control than older children. However, five year olds were found capable of producing secondary control strategies. Contrary to expectation, primary and secondary did not predict either self-esteem or SQOL. However, self-esteem predicted SQOL as expected and no sex differences were found.

Makikangas, Kinnunen and Feldt (2004), aimed to investigate the relationship between self-esteem and optimism and examined the prospective relationships between these two personality constructs, mental distress, and physical symptoms. Results showed that the latent variables of optimism and self-esteem were highly interrelated, forming the core construct of personal resilience, which turned out to be stable over the one year period. Results also indicated that high personal resilience reduced mental distress.

Hughes, Robinson-Whelen, Taylor and Swedlund (2004), determine the efficacy of a 6 week self esteem group intervention for women with disabilities, (with self-esteem, self-efficacy, social connectedness and depression, being the outcome measures). Results, showed significantly greater improvement on self-esteem. Groups however do not differ significantly on social connectedness. Women with physical disabilities may benefit from a self-esteem group intervention.

Robins (2005) opines that consensus is emerging about the way self-esteem develops across the life-span. On an average, self-esteem is relatively high in childhood, drops during adolescence (particularly for girls), rises gradually throughout adulthood, and then declines sharply in old age. Despite these general age differences, individuals tend to maintain their ordering relative to one another: Individual who have relatively high self-esteem at one point in time tend to have relatively high self-esteem years later. This type of stability (i.e. rank-order stability) is somewhat lower during childhood and old age than during adulthood, but the overall level of stability is comparable to that found for other personality characteristics.

Coping with stressful life events can be facilitated by personal and social resources, such as perceived self-efficacy and social support. This applies also to the adaptation to surgical stress and to severe diseases. Study conducted by Schwarzer and Shroder (1997) examined the presurgical personal and social resources as predictors of readjustment after heart surgery. Analysis identified an interaction between the two resources, underscoring the existence of the well known support buffer effect. Covariance structure analysis revealed that perceived self efficacy was a better predictor of recovery than social support.

Magaletta and Oliver (1999), examined the relations between hope construct, and its two essential components "will" & "ways", and the relayed constructs of self-efficacy and optimism, and the stability of hope, self-efficacy, and optimism to predict general well-being. Analysis recovered will, ways, self-efficacy, and optimism as generally distinct and independent entities. Results of multiple regression analysis predicting well-being indicated that (a) hope taken as a whole predicts unique variance independent of self-esteem and optimism, (b) will predicts, unique variance independent of self efficacy, and (c) ways predicts unique variance independent of optimism. Overall, findings suggest that will, ways, self-efficacy and optimism are related but not identical constructs.

Dwyer and Cummings (2001) examined the relationship of self-efficacy, social support, and coping strategies with stress levels of university students. Significant correlation was found for stress with total number of coping strategies and the use of avoidance focused coping strategies. Further there was a significant correlation between social support from friends and emotion focused coping strategies. Gender differences were found, with women reporting more social support from friends than men.

Chemers, Hu and Garcia (2001) examined the effects of academic self-efficacy and optimism on students academic performance, stress health and commitment to remain in school. Academic self-efficacy and optimism were strongly related to performance and indirectly through expectations and perceptions (challenge threat evaluations) on classroom performance, stress, health, and overall satisfaction and commitment to remain in school. Observed relationship corresponded closely to the hypothesized model.

Jackson & Jay (2002), examined the effect of a communication designed to enhance the self-efficacy beliefs of introductory psychology students. Results indicated self efficacy beliefs were significantly related to exam scores and significantly effected by efficacy enhancing communication.

Perceived self-efficacy represents an optimistic sense of personal competence that seems to be a pervasive phenomenon accounting for motivation and accomplishments in human beings. Scholz, Dona, Sud and Schmargzer (2002) confirmed this assumption, and suggest the globality of the underlying construct, (and points to number of cross cultural difference that merit further investigation).

The factorial dimensions of self-efficacy and self-esteem and associations among self esteem and self efficacy and scholastic achievement were explored. Five factors emerge from factorial analysis, two factors, reflected self esteem feelings (and were respectively named as self-referential self-esteem and comparative self-esteem). The remaining three factors reflected the self-efficacy beliefs in 3 different scholastic domains (linguistic literacy logical-mathematical and technical practical) All self efficacy scores were significantly related to scholastic achievement, while no association between self-esteem scores and scholastic performance were found. Nevertheless self-efficacy, and self-esteem dimensions shared some common aspects. In particular each different self-esteem factor showed different magnitude of association with domain specific self-efficacy beliefs (D'Amico, et al., 2003).

Another important variable which has been taken into account in relation to resilience factor is optimism. Is it better to be realistic or **optimistic**? According to Schneider (2001), realistic outlook improves chances to negotiate

the environment successfully, where as optimistic outlook places priority on feeling good.

It has been found that dispositional optimism facilitates subjective well being and good health is mediated by a persons coping behaviours. These results have been found in a study, which explored that personality affects quality life by influencing how people approach and react to critical life situations and the beneficial role played by two individual difference variables in promoting quality of life viz. dispositional optimism and goal adjustment (Wrosch and Scheier (2003). In addition people who confront unattainable goals were also examined. The reported evidence supports the conclusion that individual differences in people's abilities to adjust to unattainable goals are associated with a good quality of life.

Optimists tend to use more problem-focused coping strategies than do pessimists. Coping strategies preferred by more optimistic adolescents, also followed along the problem focused strategies and less anger experienced by the teenager. Also negative life events and optimism were found to be negatively related, and positive life events and optimism were positively related. However, it was concluded that the identification of optimism may be a vulnerability factor when screening adolescent mental health (Pushkar, Sereikr Lamb, Tusaie-Mumford, 1999).

Kashdan, William, Lang and Hoza (2002), examined hope as potential resiliency factor for the daily strains of raising children with disruptive behaviour disorders. In the light of the motivational component of hope theory, initiating and sustaining effort towards goals, the authors examined hope's relation to constructs addressing self-esteem, familial functioning and stress,

with 252 parents of children with externalizing disorders, completed self-report questionnaires. Significant associations were found among hope and parental and familial functioning indices. Considering their conceptual overlap, the authors tested the unique predictive power of hope and optimistic attributions on indices of psychological functioning. Separate regressions indicated that hope significantly predicted psychological functioning beyond what was accounted for by social desirability, the severity of child symptoms, and optimistic attributions. Hope agencies compared to hope pathways accounted for the vast amount of variance in regression models.

There is a growing interest in research with reference to **spirituality** as distinct from organized religion, particularly as it relates to well-being, wholeness and healing. In both professional and lay contexts, spirituality has come to the forefront of public consciousness. Once the prerogative of chaplains and clergy, nurturing of spiritual journey is now becoming a common concern. Experiencing spirituality can provide both caregivers and those for whom they care a blessed respite, for bodies, minds and spirits (Chandler, Emily, 1999).

For the psychologist, spirituality becomes an extremely relevant issue and concern because it is one of the most powerful human resources which strengthen the individual to face adversities. For those who desire to understand resilience, spirituality is an important dimension.

Vangham, (2002), suggested that spiritual intelligence is necessary for discernment in making spiritual choices that contribute to psychological well being and overall healthy human development. Spiritual intelligence is one of the several types of intelligence and it can be developed relatively

independently. It calls for multiple ways of knowing and for the integration of the inner life of mind and spirit with the outer life of work in the world. It can be cultivated through questioning, inquiry and practice. Spiritual experiences may also contribute to its development, depending on the context and means of integration. Further spiritual maturity is expressed through wisdom and compassionate action in the world.

The effects of paranormal and transcendent/spiritual experiences on people's life was investigated, by Kennedy and Kanthamani (1995). Subjects who reported having had at least paranormal or transcendental experience, reported that these experiences increased their interest and belief in spiritual matters and increased their sense of well-being. Subjects also reported that these experiences increased their beliefs in life after death, their sense of optimism about the future and their belief that their lives were guided by a higher force.

Research has examined the relationship between spiritual coping and adjustment and found that individuals employ spirituality in coping in various ways. However the reasons that individuals choose certain strategies remain unclear. The investigation, that whether spirituality mediates the relationship between attachment to goal and adjustment for individuals waiting for loved one undergoing surgery, indicated that attachment to God was related to spiritual coping activities and styles. In turn, spiritual coping was associated with the adjustment to the surgery vigil. Adjustment to God was predictive of spiritual coping, which in turn, was predictive of adjustment. Further, attachment to God provides a useful framework for understanding why individuals choose particular coping strategies (Belvaich and Pargament, 2002).

Graham, Furr, Flowers, & Burke (2001), examined the relations among and between religion, spirituality and the ability to cope with stress and the influence of religious/spiritual affiliation on comfort level regarding clients with religious/spiritual issues. 115 graduates enrolled in counseling classes completed surveys assessing their own spiritual health, religious affiliation, resources for coping with stress, and comfort level when counseling religious/spiritual clients. Results, indicate that religion and spirituality positively correlates with coping with stress. Subjects who expressed spirituality through religious beliefs had greater spiritual health and immunity to stressful situations than counseling students, who identified themselves as spiritual but not religious. Subjects with a religious/spiritual affiliation indicated more discomfort counseling clients hostile to religion compared with subject with only spiritual affiliation.

The study of relationship of spirituality with emotional and physical adjustment to daily stress, shows that spirituality buffered the adverse effect of stress on adjustment, controlling for the use of various coping strategies. The findings have implications for developing prevention programs to improve people's coping skills by incorporating greater emphasis on spirituality, Kim, Seidlitz (2002).

Nathawat and Joshi (1997), examined the effects of hardiness and type A personality on the perception of life events and psychological well-being. Results suggest that subjects with high hardiness perceived their life events more positively than subjects with low hardiness scores. Type A and Type B subjects however did not differ significantly in their perception of life events. The interaction effect of hardiness and type A was also found to be

insignificant on life events. Perception of life events and different measures of psychological well-being were significantly correlated.

Born, Chevalier and Humblet (1997) examined resilience and desistance from delinquent behaviours and attempted to identify factors which predict persistent or increased or decreased delinquency between adolescence and early childhood. Results indicate that there were important age-related differences in the characteristics which influence desistance or risk and show length of stay in an institution to be a predictor. Desistance from further delinquency seemed to depend on the time spent in the residential environment and was associated with an increase of guilt, an improvement of self-image, and attachment to one or more other people. Results, suggest that resilience is a rare phenomenon and is associated with stable relationships, absence of diagnostic label, and good adaptation to the institution.

Walsh (1996), discuss the concept of resilience, the ability to withstand and rebound from crisis and adversity, as having valuable potential for research and intervention and prevention approaches aiming to strengthen couples and families. The author advances a systematic view of resilience in ecological and developmental contexts and presents a concept of family resilience, attending to interactional processes overtime that strengthened both individual and family hardiness. The author believes that concept of family resilience offers a useful framework to identify and fortify key processes that enable families to surmount crisis and persistent stresses.

Woolfson (1995), discusses the nature of risk and moderating process of resilience. Notions of resilience enlight the complexity of psychopathology, clarify possibilities for prevention and keep hope alive in clinical practice.

Traumatic life events and chronic adversities affect children's resilience. Socioeconomic disadvantages impairments of parenting and high delinquency neighborhoods can effect children directly or indirectly. Resilience is linked to biological self-righting tendencies in human development and buffering effects and protective mechanisms that operate in the presence of stressors. An enduring aspect of the person, it evolves from interaction between the genetic and other constitutionally based qualities and is modified by life experiences, Resilience to stress and adversity can very, depending on the situation. Ways of fostering resilience at the socio-economic, familial and educational levels are discussed.

Garwick, Kohrman, Claire, Titus and Wolman (1999), investigated how Hispanic, African American, and European, American caregiving families, explain the cause of childhood chronic illness or disability and the extent to which indicators of resilience are evident in these explanations. It is concluded that families provide a variety of explanations for their children's chronic conditions that reflect their beliefs and exposure to different cultural view points and contexts. Despite these differences, common patterns of family resilience were found in family caregivers', which indicates that the concept of resilience is primarily a personality resources functioning, within a culture but not determined by a culture.

The relationship between parental perception of coping strategies and family strengths in families of young children with disabilities, was investigated by Judge (1998). The 69 participants completed the ways of coping questionnaire and the Family Hardiness Index. Results indicate that the use of social support was highly associated with the family strengths. In

contrast wishful thinking, self blame, distancing and self-control were negatively related to family strengths.

According to Rutter and Michael (1999), resilience is a term used to describe relative resistance to psychological risk experiences. There is abundant evidence that there is enormous variation in children's responses to such experiences but research to determine the processes underlying the variations needs to take into account several crucial methodological issues. The findings emphasize that multiple risk and protective factors are involved; that children vary in their vulnerability to psychological stress and adversity as a result of both genetic and environmental influences; that family experiences tend to impinge on individual children in quite different ways; that the reduction of negative and increase of positive chain reactions influences the extent to which the effects of adversity persist overtime; that new experience that open up opportunities can provide beneficial turning point effects; that although positive experiences in themselves do not exert much of a protective effect that can be helpful if they serve to neutralize some risk factors; and that the cognitive and affecting processing of experiences is likely to influence whether or not resilience develops.

Stein, Fonagy, Ferguson, and Wisman (2000) describe and illustrate an ideographic method for the study of resilience. The method assumes that resilience is an unfolding and dynamic process in which the individual and the social environment interact to produce life-course over time.

Steinhauer (2001), reviewed the literatures, the concepts through a description of various programs focusing particularly on adolescents. A number of prevention and clinical service programs are described and evaluated. These

examples from many years of evaluation and research may reinforce the thesis that support for competence and resiliency should be provided at each stage of a person's life cycle, rather than being just confined to the first few years of life.

Rew, Taylor-Sehafer; Thomas and Yockey (2001), describe reasons which adolescents give for their homelessness. They explored relationships among resilience and selected risk protective factors, identified differences in gender and sexual orientation and determined best predictors of resilience. Nearly half (47%) the subjects reported a history of sexual abuse and 36% self identified as gay, lesbian or bisexual in orientation. Over half (51%) were thrown out of their homes because their parents disapproved of their alcohol or drug use and nearly one third left home because parents sexually abuse them. Lack of resilience was significantly related to hopelessness, loneliness, life threatening behaviours and connectedness but not to gender or sexual orientation, Hopelessness and connectedness explained 50% of the variance in resilience.

Tabis (2000), studied women who care for an older family member while also caring for a child under 18 yrs. old living at home. These are known as sandwiched generation caregivers, and are at greater risk for health and psychological problems, due to competing family role, demands, and their children are at greater risk for poor adaptive outcomes due to their mothers risk status. Mental help was hypothesized to reduce caregiver risk, and thus to promote resilience among caregivers' children. 87 caregivers (aged 28-59 yrs) were randomized into two time limited, mutual help conditions and a no intervention control, and then 1 child (6 – 18 yrs) from each family was assessed at posttest and at a 6 months follow up. At post test, children of

caregivers participating in a mutual help group reported a significant decrease in depressive symptoms and the negative impact of caregiving and were found to exhibit increases in global functioning and social competence. In addition, the effects for social competence and the negative impact of care giving were sustained at follow up. Masten (2001), opines that the study of resilience in development has overturned many negative assumptions, and deficit-focused model about children growing up under the threat of disadvantage and adversity. The most surprising conclusion emerging from studies of these children is the ordinaries of resilience. An examination of converging findings from variable-focused and person-focused investigation of these phenomenon suggests that resilience is common and it usually arises from the normative functions of human adaptational systems with the grater threats to human development being those that compromise these protective systems. The conclusion that resilience is made of ordinary rather than extraordinary processes, offers more positive outlooks on human development and adaptation, as well as direction for policy and practice aimed at enhancing the development of children at risk for problems and psychopathology.

Muris and Hoogsteder (2001), studied effects of early intervention programme, group program on anxious and depressed adolescents; the Resourceful Adolescent Program is an early intervention program, designed to enhance psychological resilience. Pre and post intervention data showed reduction in anxiety and depression scores and a concomitant increase in adolescents self-efficacy.

The study conducted by Tiet, Bird, Hoven and Wu (2001) identified factors that predicted resiliency among youths who were exposed to adverse

life events, Examining main and interactive effects of child and family factors, the authors found that, on an average, children exhibited a greater degree of resilience when they had higher IQ, closer parental monitoring, better family functioning, higher educational aspiration and were female.

Lidstrom (2001) notes that change of focus from risk approach to the examination of health determinants has opened new research areas important to the development of adolescent health. These approaches one of them being resilience eventually explain the development of health, and enable the young to enjoy a full quality of life.

Turner (2001), has also explained, resilience as the capacity to bounce back in the face of adversity and to go on to live functional lives with a sense of well-being. People can become resilient even though they may have lived in stressful, neglectful family and community environment. The author describes 3 case vignettes of females (age 29-32 years) that illustrates how therapies and clients working together in a resilience framework can discover and bolster strengths that can lead to more enhanced and satisfying lives.

Renich and Shalte (2002) discusses the techniques to improve the capacity to handle life's surprises, and setbacks through resilience and individuals ability to persevere and adapt. It is maintained that resilience is what determines the happiness longevity of our relationships, our success at work, and the quality of our health. More than any other factor in the scheme of emotional intelligence, resilience is what determines how high we rise above, what threatens to wear us down. Practising the skills which enhance resilience, will result in improvement in how we communicate, make decisions and navigate through recognizing and changing the thoughts and beliefs that are subconsciously undermining resilience.

Walsh, (2003) opines that the concept of family resilience extends our understanding of healthy family functioning to situations of adversity. Although some families are shattered by crises or persistent hardship, what is remarkable is that many others emerge strengthened and more resourceful, able to love fully and raise their children well.

Power (2003) offers advice and hope for families with a child who has serious illness or disability. The Resilient Family knows how to identify the strengths that already exist in the family and then use the strengths to enable the family to flourish even in the face of burdens that feel unbearable.

Wong and Bernis,(2003) discuses several general and specific issues that pertain to the risk and resilience framework. General issues discussed include: (i) integrating current research findings with those from prior longitudinal research such as that conducted by Werner and her associates and from research in the 1980's and 1990's on problems in social perception and communication in children with learning disability, (2) measurement problems and (3) need for more differentiation in gender research and severity of L.D. There is need to continue to search for potential risk and protective factors; need to research mediating factors or mechanism that render a factor protection, and the nature of intervention research.

Margalit (2003) explains, that, development may be conceptualized as a process of repeated resilient reintegration and resilience research is expected to identify the complex transactions and processes among internal and external (risk and protective) factors involved in that process. Two mediating factors are emphasized within the third wave of resilience research: the critical role of emotions as inner source of energy and the importance of reciprocity in relation with both adults and peers.

Brennan, Le Brocque and Hammmen (2003), examined the relationship between maternal depression, parent-child relations and resilient outcomes in context of risk, defining resilient outcomes as no current Axis I diagnosis, no history of depressive disorder diagnosis, no current internalizing problems and no indication of current social functioning difficulties. Results revealed that low levels of parental psychological control, high levels of maternal warmth, and low levels of maternal over involvement all interacted with maternal depression, to predict resilient outcomes in youth targetting maternal and parental parenting qualities may be a useful method of increasing the likelihood of resilient outcomes in children of depressed mothers.

Tugada and Fedrickson (2004) points out that theory indicates that resilient individuals "bounce back" from stressful experiences quickly and effectively. Among theories that provide empirical evidence of this theory, is the broaden and build theory of positive emotions, (Fredrickson, 1998, 2001), which is used as a framework for understanding psychological resilience. The authors used multi method approach in 3 studies to predict that resilient people use positive emotions to rebound from, and find positive meaning in stressful encounters. The analyses revealed that the experience of positive emotions contributed, in part, participants' abilities to achieve efficient motion regulation, demonstrated by accelerate cardiovascular recovery from negative emotional arousal and by finding positive meaning in negative circumstances.

Smith, Young and Lee (2004), examines whether optimism and health-related hardiness contribute to health and well-being among older women. Positive psychological characteristics, including optimism and health related hardiness, are correlated with good self-rated health, but these variables are all

affected by socioeconomic status, social support, physical illness and access to services. Data from 9501 Australian women aged 73 to 78, show that optimism and health related hardiness explain a significant proportion of variance in all subscales of the SF-36, and in stress, even after these confounders are taken into account. The data although cross-sectional, suggest that positive personal characteristics may contribute to well-being.

For centuries, folk theory has promoted the idea that positive emotions are good for your health. Tugada, Fedrickson and Barrett (2004) used the broaden and build theory of positive emotions (Fredrickson, 1998; 2001) as a framework to demonstrate that positive emotions contribute to psychological and physical well being via more effective coping. (It was argued, that health benefits advanced by positive emotions may be instantiated in certain traits that are characterized by the experience of positive emotion. The authors examined the individual difference in psychological resilience (the ability to bounce back from negative events by use positive emotions to cope) and emotional granularity (the tendency to represent experiences of positive emotion with precision and specificity). Individual differences in these traits are examined in two studies, one using psychological evidence, the second using evidence from experience sampling, to demonstrate that positive emotions play a crucial role in enhancing coping resources in the face of negative events.

Although clinicians and researchers are increasingly interested in understanding mental health, the systematic study of resiliency presents unique problems. Constructs of mental health have been used in epedemiologic, population – based studies of wellness. Sociability, self-efficacy, and a sense of meaning appear to be common attributes of resilient people. These attributes

seem to benefit individuals over time and despite hardships, (Bromley, Elizabeth, 2005).

Brooks (2005) examines a more inclusive definition of resilience that embraces all youngsters and encourages us to consider and adopt parenting practices that are essential for preparing children for success and satisfaction in their future lives. A guiding principle in each interaction which parents have with children should be to strengthen their ability to meet life challenges with thoughtfulness, confidence, purpose, responsibility, empathy and hope. These qualities may be subsumed under the concept of resilience.. The development of a resilient mindset, is not rooted in the number of adversities experienced by a child but rather in particular skills and positive attitude that caregivers re-in force in a child.

PARENTAL ACCEPTANCE

The child's early environment is primarily limited to home and family relationships. Parents play a dominant role in determining what sort of a person, the child will grow upto be. Parents' relationship with the child is the key influence in guiding personality development.

Research has shown that early months of life are tremendously important in starting the infant on the pathway of healthy or unhealthy development. Psychologists on the basis of the information gathered through interviews, questionnaire, and rating of parents and children suggested the importance of two dimensions of parental behaviour; acceptance – rejection and permissiveness restrictiveness (Becker, 1964, Martin, 1975, Sears, Maccoby and Lewin, 1957, Symonds, 1939). These dimensions have undergone the most intensive examination.

Parental acceptance, leading to the normal emotional development of the child, paves the path for all sorts of progress in life. It includes love, affection recognition that a child receives from his parents inspite of all his naughtiness and misbehaviour that he may show.

Acceptance-rejection refers to the respect and love or lack of both – that parents feel for their children. At the extreme, accepting parents show warmth, affection, approval and understanding. Rejecting parents on the other hand, are cold, disapproving and punitive. They do not enjoy their child nor are they sensitive to his needs.

According to Symonds (1939) accepted are more cooperative, socialized, friendly, have highly valued personal characteristics and are happier and more stable than the rejected group of children.

Sharan (1987) examined parental role in fostering of creativity. The degree of emotional bonding with the parents, parental care, sense of being rewarded/not rewarded; punished / not punished, being respected in the family etc. were studied. Results indicate that presence of father has non-significant role in determining verbal creativity where as, the presence of father figure positively and significantly effects the development of non-verbal creativity. Although the study was conducted on non-handicapped groups, the conclusions are in all the probability relevant for all handicapped groups also.

In a study of two groups of persons coming from favourable and unfavourable environments of home respectively, Powers and Witmers (1974) found that all the boys who turned out well, had parents whose attitude towards them was rated "favourable" and almost all who were neurotic and delinquent had parents whose relationships with them were them were "unfavourable".

Mactaush, and Schleien (1998), examined the benefits of family recreation in families that include children with developmental disabilities. Results of the analyses revealed that family recreation was perceived by parents as a positive means for promoting the over all quality of family life (i.e. unity, satisfaction, health) and for helping its members to develop life – long skills (recreation, physical, social) and values. These benefits were considered to be of particular importance for children with developmental disabilities and families viewed themselves as playing a critical role ensuring their attainment. As such, family recreation was not only viewed as a beneficial catalyst for skill, interest and self-development, but as potentially the most accepting and enduring social and recreation out let for children with developmental disability.

Jain (1998) examines the influence of parental acceptance on a child's mental health as measured by emotionality, timidity, apprehension, and tension, that is, factors C,H,O, and Q4 of cattell's 16 PF Test. Results reveals that the less accepted groups was significantly more emotionally unstable, timid, apprehensive, and tense than the highly accepted group.

Ohamnessian, Clearner, and Voneye (1998), examined relationship between perceived parental acceptance and adolescent self competence in 214 sixth and seventh grade students by both adolescents and parental gender. Specific measure of adolescent self competence focused on academic, athletic, and social competence, as well as physical appearance and self worth. Results indicate that for boys parental/but not maternal acceptance significantly predicted self-competence, while the opposite pattern was found for girls. In addition self-worth significantly predicted maternal and parental acceptance for both boys and girls.

Kernis, Brown and Brody (2000) examined children's self-esteem stability and level related to their perceptions of various aspects of parent-child communication. Compared to children with stable self-esteem, children with unstable self esteem reported that their fathers were more critical and psychologically controlling and less likely to acknowledge their positive behaviours or to show their approval in value affirming ways. Likewise, children with low self-esteem reported that their fathers exhibited these qualities to a greater extent than did the children with high SE. In addition fathers of children with stable SE were viewed as especially good at problem solving. Children's SE level related to perceptions of mothers' communication style very similarly to how it did with the fathers'; with respect to SE stability, however, relationships were generally less consistent and frequently absent.

Relationships among perceived parental rejection, control and personality characteristics of children were investigated. Results revealed that children perceive their fathers to be significantly more neglecting whereas mothers are perceived as more accepting than fathers. Parents appear to be moderate in controlling children's behaviour, which adds to their perception of parental warmth and acceptance (Riaz, 2003).

Scales, Benson, Rolhkepartain and Hintz (2004), investigated how parental status and age of child might affect patterns of adult engagement with children and youth outside their own families. Compared to nonparents, parents considered 12 of 20 ways of being involved with young people, to be significantly more important for all adults to do. This result suggests that fears of negative parent reaction about other adults' involvement may be exaggerated. Parents and non parents alike rated it more important for unrelated

adults to engage with children than with adolescents, and adults in general actually engaged more with those younger children than with adolescents. Community efforts that raise explicit awareness of how supportive parents are of such relationships may help create new social norms in which positive engagement with other peoples children is expected and supported.

Laible and Carlo (2004), examine how the parenting dimensions of both mothers and fathers independently and together predict adolescent outcomes in three domains sympathy, self-worth and social competence. Perceived maternal support and rigid control were the most consistent predictors of adolescent adjustment, High levels of perceived maternal support and low levels of maternal rigid control were related to adolescents' reports of sympathy, social competence and self-worth. In contrast, support and control from fathers was generally unrelated to adolescent adjustment. The one exception was in predicting sympathy, where father support interacted with maternal support in predicting sympathy. When perceived support from fathers was high, maternal support was unrelated to sympathy. In contrast, when perceived support from fathers was low, perceived maternal support was a statistically significant predictor of sympathy.

Previous research had established the link between harsh parenting and poor outcomes in children, although little attention had been paid to the concurrent protective factors which may exist. The relationship between parenting behaviours and childhood externalizing behaviors was investigated by Nicholson and Fox, (2005). Results indicate that parents of young children with externalizing behaviours tended to use more frequent verbal and corporal punishment with their young children, and reported more behaviour problems

with their young children when compared with control group. However no significant differences were found between groups with respect to positive, nurturing behaviours, or utilizing appropriate developmental expectations.

Parker and Benson (2005), examined parental support and monitoring as they relate to adolescent outcomes. It was hypothesized that support and monitoring would be associated with higher self esteem and less risky behaviour during adolescence. Both high parental support and parenting monitoring were related to greater self-esteem and low risk behaviours.

Bamaca, Umana-Taylor, Shin and Alfaro (2005), examined the relations among parenting behaviours, adolescents' self-esteem, and neighbourhood risk. The findings suggest that boys' self-esteem is influenced by both mothers and fathers parenting behaviours, whereas as girls' self-esteem is influence by mothers' behaviours only. In addition, the findings provide partial support for the notion that parenting influences on psychological outcomes vary based on neighbourhood context.

DeMinzi and Maria (2006), analysed the relationship between parenting and attachment and (b) self competence, loneliness, and depression in children 8-12 years. Results indicated that attachment and parent child relationship styles were differentiated constructs. Parents acceptance promoted secure attachment and positive outcomes in children. Moreover, fathers' lack of interest had a marked negative effect. The author found differences in the perceptions and influences of fathers and mothers, which follow the cultural patterns of gender attribution.

Woolfson and Lisa (2005) discuses the challenges faced by parents of disabled children and the help available to them from psychological theory.

Recent research has focused on effective use of cognitive change in adapting to parenting a disabled child. Other psychological frameworks include the self regulation model for exploring patients' view of their illness and how these regulate coping outcomes, and attribution theory. It is suggested that, on the one hand attributing responsibility to the child for problematic behaviour is linked with parental negative emotional reaction that is itself associated with harsh parental behaviour responses and aggressive child behaviour, on the other hand in order to begin to effect change in their children's behaviour, parents need to view their children as having some responsibility and control over their behavior. Trying to achieve behavioural change, with its implications of parental and child responsibility and the negative affect that may be associated with this, an additional key area suggested for psychologists is provision of emotional support for parents who are engaged in such an emotionally demanding task.

Amongst the various factors, resilience (the capacity withstand stressors, and bounce back from adversities) and parental acceptance, have also been found to be related to one's well-being. Higher resilience and greater life satisfaction were found to be strongest predictors of psychological well being. Thus, from the above mentioned studies it seems that well-being is the primary and foremost goal of human beings and resilience (the inner capacity) and parental acceptance (the external support system) contributes to one's well-being.

The above review of empirical work done points to the fact that resilience is one of the important qualities which can play a role in enhancing the quality of life of groups with special challenges. The personal resources which resilient

qualities makes available and social support which parental acceptance places at disposal may possibly be powerful predictors of well-being.

Since the concept of resilience is a holistic concept and many specific factors contribute to total resilience, it is possible to study resilience as a single broad factor or study it in terms of its specific component factors. Both types of approaches have been adopted by researchers. In the present research, resilience is being studied amongst a special group, namely orthopaedically challenged, together with normal sample. Therefore a more clear and meaningful picture would emerge of resilience as a total factor together with each specific factor is studied.

On the basis of various empirical findings and theoretical formulations, the following hypotheses were framed for our research entitled "Resilience and Parental Acceptance as Determinant of Sense of Well-Being amongst Disabled". It may be noted that resilience is being studied in terms of its 6 compound factor as well as a total factor.

1. Orthopaedically disabled subjects with high self-esteem experience greater well-being than orthopaedically disabled subjects with low self-esteem.
2. Orthopaedically disabled subjects with high self-efficacy experience greater well-being than orthopaedically disabled subjects with low self-efficacy.
3. Orthopaedically disabled subjects with high perseverance and tenacity experience greater well-being than orthopaedically disabled subjects with low perseverance and tenacity.

4. Orthopaedically disabled subjects high on perception of social acceptability experience greater well-being than subjects with low on perception of social acceptability.

5. Orthopaedically disabled subjects with high optimism experience greater well-being than subjects low optimism.

6. Orthopaedically disabled subjects with high spirituality experience greater well-being than orthopaedically disabled subjects with low spirituality.

7. Orthopaedically disabled subjects with high resilience experience greater well-being than orthopaedically disabled subjects with low resilience.

8. Orthopaedically disabled subjects with high parental acceptance experience greater well-being than orthopaedically disabled subjects with low parental acceptance.

9. Female orthopaedically disabled subjects experience lower well-being as compared to male orthopaedically disabled subjects.

10. Orthopaedically disabled subjects falling in low age group will differ on well-being from orthopaedically disabled subjects in high age group.

Since it is desirable to have a picture of the phenomenon in the non-disabled sample in order to achieve a better understanding of the disabled, the following hypotheses were also formulated.

11. Non-disabled subjects with high self-esteem experience high well-being than non-disabled subjects with low self-esteem.

12. Non-disabled subjects with high self-efficacy experience greater well-being than non-disabled subjects with low self-efficacy.

13. Non-disabled subjects with high perseverance and tenacity experience greater well being than non-disabled subjects with low perseverance and tenacity.

14. Non-disabled subject high on perception of social acceptability experience greater well-being have non-disabled subjects low on perception of social acceptability.

15. Non-disabled subjects with high optimism experience greater well-being than subjects with low optimism.

16. Non-disabled subjects with high spirituality experience greater well-being than non-disabled subjects with low spirituality.

17. Non-disabled subjects with high resilience experience greater well being than non-disabled subjects with low resilience.

18. Non-disabled subjects with high parental acceptance experience greater well-being than non-disabled subjects with low parental acceptance.

19. Female non-disabled subject experience lower well-being than male non-disabled subjects.

20. Non-disabled subjects falling in low age group experience differ on well-being from non-disabled subjects in high age group.

The details of methodology adopted by the researcher are given in the next chapter.

Chapter III

METHODOLOGY

The main thrust of the present research is to throw light on the phenomenon of well-being of disabled persons by exploring how resilience and parental acceptance contribute to the well being of disabled individuals.

The research focuses on the following broad questions :

- Do disabled persons high on resilience experience greater well-being than those low on resilience.
- Do disabled persons with parents showing greater acceptance have higher sense of well-being than those with parents showing low acceptance.

Three important variables needed to be studied by the researcher, namely resilience, parental acceptance and well-being. Appropriate tools for studying well-being and parental acceptance were available. The researcher reviewed the various tests available to study resilience eg. Waglind and Young (1993), but in view of age group and other characteristics of the sample, these were not felt to be appropriate. Thus it, become necessary to develop a test to measure resilience. Therefore another major dimension was added to the present research, namely devising of measure to study resilience.

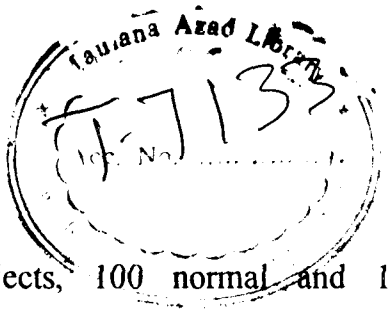
Test construction is one of the most challenging and crucial activities in research. Preparing a good test is both time consuming and involves exercise of great care and control. According to Kelly (1969) and Hasan (1997) there are three strategies for construction of questionnaire.

1. Rational theoretical
2. Empirical
3. Factor analytic

The researcher used the Rational theoretical method together with factor analytic method for construction of Resilience scale. Details in this regard are being covered in the section on "Tools of Study" in the forthcoming pages.

DESIGN

The present research aims to study the role of resilience and parental acceptance with regard to well-being amongst disabled. It aims to explore whether resilience and parental acceptance contribute to well-being. The researcher felt that gender and age are two other important psychosocial factors which should also be taken into account. Further six factors had emerged in factor analysis as components of resilience and parental acceptance was another variable which formed focus of study. Therefore a total number of ten independent variables, namely, self-esteem, self-efficacy, perseverance and tenacity, perception of social acceptability, optimism, spirituality, gender and age; form part of the study in the context of feelings of well-being. Therefore two groups were formed in terms of each variable under study and with the help of t-test, significance of difference between the two group on the dependent variable were studied. The researcher also wanted to study the degree to which status existing in the sample could predict the status in the population. Since the criteria on which the two groups were identified was a psychological variable (e.g. resilience, parental acceptance etc.), the kind of difference that emerges from the t-test may be deemed to be a relationship (Field, 2000). Therefore appropriate analysis towards this end, reported under 'Statistical Analysis' was done. Therefore our design, though predominantly a two group design has characteristics of correlational design also.



SAMPLE

The sample comprised of 200 subjects, 100 normal and 100 orthopaedically handicapped. The age range of sample was 8 years to 16 years. Number of male subjects were 100 and number of females also 100. fifty subjects of each gender group were in the disabled and non-disabled category. Drawing of sample through random procedures is undoubtedly desirable but even in pure experimental research it is a difficult proposition. According to Broota (1989) "randomization is necessary to ensure validity of independence assumptions, in practice, it is generally difficult to follow dictates set forth by the theory of random sampling. Usually we include, as subjects those members of the population that are easily accessible to us." It is therefore, advisable that the researcher should draw subjects at random from those subjects that are easily accessible to him/her. In the present research too, this was followed. An attempt was made to ensure that equal number of males and females (normal and orthopaedically disabled) should be part of the sample. The data was collected from the following institutions :

1. Institute for the Physically Handicapped (Ministry of Social Justice and Empowerment, Govt. of India), 4, Vishnu Digamber Marg, New Delhi-110002.
2. Jawaharlal Nehru Medical College, Aligarh Muslim University, Aligarh.
3. At Barkat School, Anoop Shahar Road, Aligarh.
4. Green Crescent School, Medical Road, Aligarh.
5. Our Lady of Fatima School, Ramghat Road, Aligarh.

TOOLS OF STUDY

1. RESILIENCE SCALE

After surveying and scrutinizing the various tests available for studying resilience, the researcher felt that in view of the age group being studied and the characteristics of the group under study, it was necessary that appropriate tool be developed. The rational theoretical method was felt to be most suitable for this purpose. The following steps were involved in scale construction :

The first step was defining of construct. In this, the definition of the trait is to be enunciated. If the psychologist is depending upon some theoretical formulation in deciding what he/she has to measure, then the investigator can draw out the definition from various sources.

With the help of empirical studies and literature the researcher prepared a comprehensive picture of the concept of resilience. The factors which were found predominantly in most definitions included self-esteem, self-efficacy, competence, spirituality (in terms of sense of purpose and meaning), optimism, hope, feeling of being socially acceptable, perseverance and tenacity.

A pool of items which reflected each of the factors defining resilience was created, with the help of teachers of the department and senior research scholars. Initially more than fifty questions were formulated. Each item highlighted a situation reflecting a particular factor. Experts subjected these questions to scrutiny. Three teachers and two research scholars participated in this. Their comments were incorporated, further adjusting the construction and wording of statements. Many unrelated questions were deleted.

The next step was editing and improving language of items. Since one of the fundamental assumptions of rational theoretical approach is that the responses given by a subject are the verbal representation of his mental interior, the items in the instrument should convey the same meaning to all the subjects so as to have a sample of their same kind of mental interior. To ensure that all the subjects get the same meaning of statements, the statements should be easy to understand and not open to more than one interpretation. Some informal criteria for the editing of statements given by Edwards (1969) can be used for the selection of items. The criteria are :

- Avoid statements, which can be interpreted in more than one way.
- Avoid statements, which are likely to be endorsed by every one or almost by no one.
- Select statements that cover the entire range of variations along the continuum.
- Keep language of statement simple, clear and direct.
- Keep statements short.
- Each statement should contain one complete reference of feeling or behaviour.
- Statements should avoid such words as "always", 'all', 'none', 'never', etc. because universals introduce ambiguity.
- Words such as 'only', 'just', 'merely' and others of similar nature should be used with care and moderation in writing statements.
- As far as possible statements should be in the form of simple rather than complex sentences.

- Avoid words that are not understood by those who have to give responses.
- Avoid use of double negatives.

This was diligently followed and the next step undertaken was screening and rewording of items, which was done with the help of experienced researchers. This helped to establish face validity.

Determining item homogeneity was the next step. A rational – theoretical approach is developed to assess individual differences in respect to the trait to be assessed. The total score obtained by adding the scores assigned to individual items should have the contribution of only one source but this is possible only when all the items comprising the scale are consistent due to their being the measure of the same characteristic.

For determining item homogeneity, the researcher has applied factor analytic approach (principal component analysis). Methodologically speaking, this is one of the best methods to establish homogeneity amongst items when more than one factor has to be studied and homogeneity amongst items of each factor has to be established. It has been pointed out by Kelly (1969) that while making use of any tool development strategy, no strategy provides a complete and adequate basis for developing the tool that a particular research psychologist may need in order to obtain a better understanding of personality. Both Kelly and Hasan (1997) pointed out that only by using each of these strategies (rational theoretical, empirical, and factor analytic approach) at appropriate but different stages in the development of assessment devices it is possible for us to avoid the limitations of each strategy and to develop assessment instrument which can both further the understanding of personality and permit the accurate prediction of important behaviours. Therefore the present researcher made use of the factor analytic approach at the stage of determining homogeneity.

To assess the adequacy of the sample for the factor analysis, Kaiser-Meyer-Olkin statistics was applied. This statistics indicates the proportion of variance in the items (initial number of items was 49). This test measures the extent of common variance within the items caused by underlying factors.

The value of Kaiser-Meyer-Olkin (KMO) Measure of sampling Adequacy is .658. This value ranges from 0 to 1. The closer this value to 0 the higher the diffusion in the pattern of correlation and sample becomes more in appropriate. In our case the KMO value is above .5 which shows that the sample is appropriate to conduct factor analysis.

Another test of fitness is Bartlett's test of Sphericity which tests the null hypothesis that the correlation matrix of our variables is identity matrix (all the correlation coefficients on this R matrix are zero). In case of being our R-matrix an identity one, we cannot go on with the factor analysis. In other words, there should exist some relationship amongst the variables.

Bartlett's Test of Sphericity

Chi-Square	2681.183
df	946
Sig.	.000

Our results on this test are highly significant which indicate that our correlational matrix is not an identity matrix and we can proceed with factor analysis.

Extraction of factors : Factor analysis was conducted following the principal component analysis. Cut point for the initial entry of correlation value was .03.

Eigen values : Eigen values were calculated to determine the linear components within the data set of the R-matrix. The criteria to include a particular vector (mathematical representative of a factor) was 1. Vectors

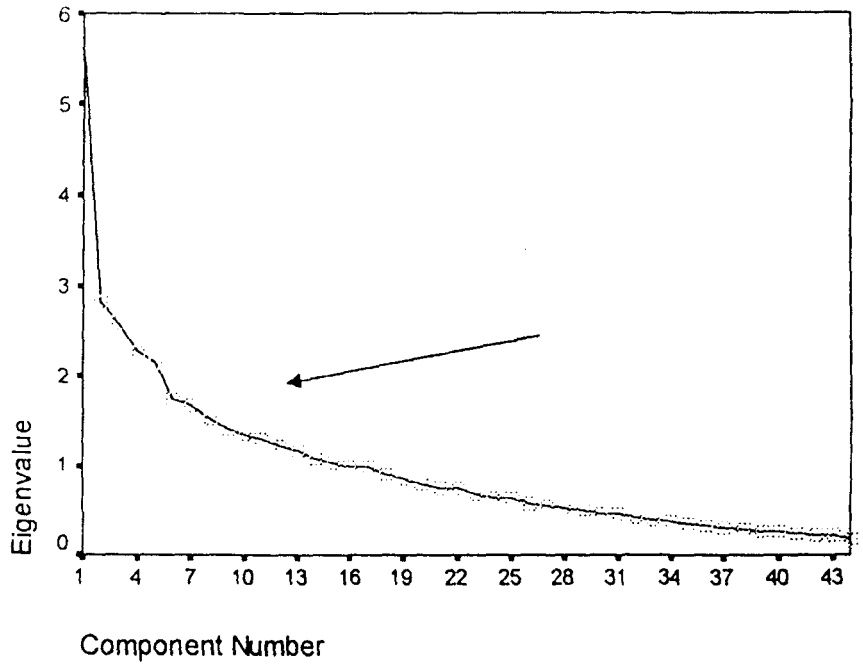
showing value of associated eigen values 1 or more than one were considered for extraction. Initially there were 16 such groups having associated eigen values 1 or more than one. Following a subjective decision to limit the number of factors within the scale, only six factors of high variance were retained. These six factors were subjected to varimax rotation. Details regarding these factors is displayed in the following table:

Description of Eigen values

Component	Extracted			Rotated		
	Total	% of variance	Cumulative %	Total	% of variance	Cumulative %
1	5.672	12.891	12.891	3.810	8.659	8.659
2	2.817	6.403	19.293	3.036	6.899	15.558
3	2.607	5.925	25.219	2.829	6.429	21.987
4	2.261	5.139	30.358	2.800	6.364	28.351
5	2.152	4.890	35.248	2.760	6.273	34.624
6	1.738	3.949	39.197	2.012	4.573	39.197

Following scree plot helps to explain the status of variance contributed by each component.

Scree Plot



Rotation : Rotation clarifies which item relates to which factors in a more clear way (which was not before rotation). We intended to keep our factors independent of each other within a scale, therefore we choose to apply varimax rotation. In this way our components get organized in more interpretable clusters because varimax method maximizes the dispersion of loadings within the factor. A matrix of rotated variables which were loaded on six factors is given in the following table. Loading values below .3 were not considered therefore were suppressed (and we see some table cells are blank).

Rotated Component Matrix

	Factors					
	1	2	3	4	5	6
Q1	.322			-.318		
Q2				.596		
Q3			.528			
Q4			-.353	.347	.384	
Q5		.564				
Q6						.523
Q7	.337		.458			
Q8						.498
Q9				.547		
Q10		.477				
Q11						.502
Q12	.317				.437	
Q13	-.347				.403	
Q14				.512		
Q15						.475
Q16	.457				.350	
Q17	.653					
Q18	.417	.471				
Q19			.383		.561	
Q20			.427			
Q21	.419	.320				
Q22		.327			.322	
Q23	.348					

Q24					.434	.536
Q25	.649					
Q26		.338		.365		
Q27			.552			
Q28			.332	.572		
Q29	.588			.303		
Q30		.619				
Q31					.545	
Q32		.388	.370			
Q33	.687					
Q34	.342			.378		
Q35		.394			.363	
Q36	.361			.609		
Q37		.468				
Q38	.426				.569	
Q39			.338			
Q40					.589	
Q41			.448			
Q42			.586	.318		
Q43			.404			.390
Q44	.384	.459				

While organizing the items in the factors, in case of multiple loadings, maximum loading values were considered. These six factors were given appropriate sub-titles after face validity confirmed that they measure a particular kind of psychological attribute. The final scale was subjected to the Cronbach alpha reliability and Guttman Split Half reliabilities. The Cronbach alpha was found to be .816 and Guttman split half reliability is .804.

Thus, after factor analysis, six factors clearly emerged, (1) self esteem, (2) self efficacy, (3) perseverance and tenacity, (4) perception of social acceptability, (5) optimism, and (6) spirituality (in terms of sense of purpose and meaning). Some of the factors which we had conceptualized to be distinct

and therefore framed items which referred to each (e.g. competence and self efficacy) were brought out as one single factor in factor analysis. The same was with perseverance and tenacity and with spirituality, purpose and meaning. Since the researcher observed that terms which were found to refer to one common factor though semantically different, had in essence a basic similarity, there was no loss of meaning in terms of the definitions which the researcher started with. And thus, the resilience scale, comprising of forty four items was constructed.

Four response categories, viz. 'Always, 'Often', 'Sometimes' and 'Never'. were provided against each item and subjects were asked to put a tick mark (√) in front of each item in its respective column. Scores, range from 4 to 1 respectively. The maximum possible score is 176 and the minimum score is 44.

2. Parental Acceptance Scale :

In order to study parental acceptance, the researcher used the parental acceptance scale constructed by Ansari (1975). The scale measures attitude and behaviour of parents towards children as experienced and perceived by the children themselves. The scale consists of 29 items indicating the behaviour of parents in their daily life with their children. It has been used extensively by researches in the area of education and psychology.

Four response categories, viz, 'Always', 'sometimes', 'often' and 'Never'. were provided against each item and subjects were asked to put a tick mark (√) in front of each item in its respective column. Scores ranged from 1 to 4, depending upon the direction. An item expressing acceptance by parents is scored 4 if marked always, 3 if marked often, 2 for sometimes and 1 for never.

The scoring is reversed in case of an item indicating non-acceptance or rejection. The split-half reliability have been found to be 0.81. The face validity of the parental acceptance scale had been determined. As contents were based on a careful consideration of the behavioural criteria of acceptance of children by their parents and the items had been formulated after discussion with teachers and students of psychology, it may be said that the scale is a valid measure of parental acceptance as perceived by children.

3. WELL-BEING SCALE

In order to measure well-being, the researcher used the PGI Well Being Scale, standardized by Verma et al. (1986). The scale used to assess general Well-being. The scale consists of 20 items and is constructed on the lines of scales by Faizo (1977). Earlier, it had 25 items, but later on certain items were deleted and the scale was simplified to suit the Indian conditions. It resulted in 20 item scales named PGI General Well Being Scale. It deals with various aspects of well-being such as worry distress, life satisfaction, control etc. The response categories viz. 'Yes' and 'NO' were provided against each item. The subjects were asked to put a tick mark (√) or cross (x) against each item indicating the presence or absence of item, respectively. The scores range from '1' to '0'. An item expressing presence marked was scored 1 and if marked x was scored 0. It is found to have satisfactory validity and high reliability. The test-retest reliability is .8 and inter-rater reliability is .86

PROCEDURE

Administration of questionnaire is one of the most important activities in the conduct of research. It has to be conducted with sensitivity and

because the subjects serious and genuine reactions will come if rapport is established and confidence in the researchers integrity and respect for confidentiality is also created, the researcher made sincere and concerted efforts in this direction.

The questionnaires were administered individually after establishment of a healthy trustful relationship. Subjects made queries wherever desired. Since it is difficult to contact a particular subject on different occasions, the researcher administered the questionnaires in one day, giving short breaks to the subject. Since the questionnaires were not very long, subjects did not feel any difficulty, particularly as the atmosphere created was interactive and not monotonous.

The administration of questionnaire is a great learning experience for research scholar. It may be a taxing venture to motivate respondents and to ensure that they all understand what is being asked, but it pays rich dividends to the research scholar, by creating a feeling that honest and genuine research has been conducted.

STATISTICAL ANALYSIS

Since the purpose of the present study was to find out the role of resilience factors comprising resilience, parental acceptance and certain psychosocial variables on sense of well-being, analyses was conducted accordingly. For each of the independent variable the high scores and low scorers amongst disabled (identified on the basis of P_{25} and P_{75}) were compared on their mean scores on sense of well-being. For age, the upper age group was identified as 12 years and above and low age group as below 10 years. The significance of difference between mean was calculated with the help of t-test.

Since the researcher wishes that prediction about mean difference in population should also become available, 95% confidence internal of the mean difference was also computed.

We have taken mean values of well-being of the two independent groups, therefore we compute distance (difference) between the two means in order to calculate a t-value. Thus, 'mean difference' becomes an important value. 95% confidence interval of this value indicates the possible range of this value within a population. The lesser the difference between the lower and upper limit, the more dependable our result. Major point of dependability is either both the values are negative or positive. If lower limit is negative and upper limit is positive it shows that it contains 'zero' within the range. Furthermore, there are chances that in some cases the mean difference can be zero which indicates that there is no difference. Therefore, 95% confidence interval helps to extrapolate our mean difference within the population assuming that if we conduct our experiment and compute mean difference on 100 samples from the same population, there are chances that 95 times mean difference will fall within the lower limit and the upper limit.

Since factor analysis (principal component analysis) was a major aspect of construction of resilience scale, the following statistical analyses were also conducted –

(1) Kaiser Meyer – Olkin (KMO) Measure

(2) Bartlett's test of sphericity

The statistical analysis was conducted with the help of SPSS 11 software.

Chapter IV

RESULTS

Results obtained by the researcher after statistical analyses, are being reported in this chapter. The status of each of the hypotheses formulated can be evaluated from the tables given. Each table together with clarifications given below it, gives a clear picture of the phenomena being studied.

Table 1

Showing significance of difference of well-being scores of high and low self-esteem groups (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High Self-esteem	23	12.22	2.907	.37	.478	.635	-1.202	1.949
Low Self-esteem	22	12.59	2.282					

The above table shows results of an independent sample t-test which is conducted to compare mean well-being of group of subjects which is high on the self-esteem and the group which is low on self-esteem. Results indicate that subjects high on self-esteem and subjects low on self-esteem differ very slightly on their means of well being. The computed t-value for mean difference is .478 which is not significant at .05. This indicates that mean difference is statistically non-significant.

We find the mean difference between the two values i.e. .37 falls within the confidence limit at 95% (chances of means difference falling between the values of –1.202 and 1.949 is 95%). Detailed discussion in this regard has been

undertaken in the chapter on methodology. Since, the t-value is not significant the aspect of mean difference need not be discussed here.

Therefore, our hypothesis namely that **orthopaedically disabled subjects with high self-esteem experience greater well-being than orthopaedically disabled subjects with low self-esteem** is ***rejected.***

Table 2

Showing significance of difference of well-being scores of high and low self-efficacy groups (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High Self-efficacy	24	12.83	2.200	-1.60	2.478	.016	-2.885	-.308
Low Self-efficacy	38	11.24	2.625					

The results of an independent sample t-test conducted to compare mean well-being of a group of subjects which is high on self-efficacy and the group of subjects which is low on self-efficacy, are reported in Table 2.

It can be seen that subjects who are high on self-efficacy have higher level of well-being than subjects who are low on this dimension. Computed t-value is 2.478, which is significant at .05 level. This indicates that the mean difference of well-being is statistically significant.

The mean difference between two values i.e. –1.60 falls within the confidence limit at 95% (chances of mean difference falling between the values of –2.885 and -.308 is 95%). Since the lower limit and the upper limit of 95%

of the confidence interval of mean difference are both in the same direction (-2.885 and -.308 respectively), it may be predicted that in the population also the value will range within these limits. In simple words there are high chances (95%) that the phenomena will occur in the population also.

It is observed that group high on self-efficacy has mean score of 12.83 on well-being and those with low-self efficacy has mean score of 11.24. Therefore, our hypothesis, **orthopaedically disabled subjects with high self-efficacy experience greater well-being than orthopaedically disabled subjects with low self-efficacy** is ***supported*** by results.

Table 3

Showing significance of difference of well-being scores of high and low perseverance and tenacity groups (disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High perseverance & tenacity	24	12.29	2.349	-.82	1.298	.199	-2.078	.442
Low perseverance & tenacity	38	11.47	2.458					

Table 3 shows the results of an independent sample t-test which is conducted to compare mean well-being of a group of subjects which is high on perseverance and tenacity and the group which is low on perseverance and tenacity.

The computed t-value for mean difference is 1.298, which is not significant at .05. The mean difference between the two values i.e. -.82 falls within the confidence limit at 95% (chances of mean difference falling between the values of –2.078 and .44 is 95%). However since the t-value obtained is not significant, the question of prediction in the population does not arise.

Our hypothesis that **orthopaedically disabled subjects with high perseverance and tenacity experience greater well-being than subjects with how perseverance and tenacity** is ***rejected.***

Table 4

Showing significance of difference of well being scores of high and low perception of social acceptability groups (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High perception of social acceptability	18	13.17	2.307	-1.31	1.902	.063	-2.701	.074
Low perception of social acceptability	34	11.85	2.401					

The results of an independent sample t-test conducted to compare mean well-being of group of subjects high on perception of social acceptability and group of subjects low on perception of social acceptability, are reported in the table 4.

Results show that subjects high on perception of social acceptability have higher levels of well-being than subjects low on this dimension.

Computed t-value is 1.902, which is significant at .05, that is the mean difference is statistically significant.

The mean difference, between the two values i.e. –1.31 falls within the confidence limit at 95% (chances of mean difference falling between the values of –2.701 and .074 is 95%). But the upper limit (.074) and the lower limit (-2.701) are in different directions. Thus we cannot predict that this will occur in the population also. This is not a dependable value for the prediction of the population.

However, the computed t-value (1.902) is significant, therefore our hypothesis namely that **orthopaedically disabled subjects high on perception of social acceptability will experience high well-being than orthopaedically disabled subject low on perception of social acceptability** is ***accepted.***

Table 5

Showing significance of difference of well being scores of high and low optimism groups (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High Optimism	26	13.27	1.951	-2.05	3.305	.002	-2.05	.621
Low Optimism	23	11.22	2.392					

The above table shows the results of an independent sample t-test which was conducted to compare mean well-being of a group of subjects which are high on optimism and subjects which are low on optimism.

Our results indicate that subjects who are high on optimism have higher level of well-being than subjects with low levels of optimism. Computed t-value is 3.305 which is significant at 0.05. This indicates that the mean difference of well-being between the two groups is statistically significant.

The mean difference between the two values i.e. –2.05 falls with the confidence limit 95% (chances of mean difference falling between the values of –2.05 and -.621 is 95%). Since the lower limit (-2.05) and the upper limit (.621) are in different directions we cannot predict the same results to occur in the population also.

However, our t-value is significant. The mean score on well-being of high optimism group is 13.27, and the mean score of low optimism group is 11.32, therefore our hypothesis, **orthopaedically disabled subjects with high optimism will experience greater well-being than orthopaedically disabled subjects with low optimism** is ***ratified.***

Table 6

Showing significance of difference of well being scores of high and low Spirituality groups (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High spirituality	21	12.29	2.795	-.64	.834	.408	-2.193	.907
Low spirituality	28	11.64	2.571					

The above table shows the results of an independent sample t-test which was conducted to compare mean well-being of a group of subjects which is high on spirituality and subjects which is low on spirituality. Computed t value

for the mean difference is .834 which is not significant at .05. This indicates that the mean difference is statistically non-significant. Since t-value is not significant, the question of studying prediction in population does not arise.

Our hypothesis – **orthopaedically disabled subjects with high spirituality will experience greater well-being than orthopaedically disabled subjects with low spirituality** is ***rejected.***

Table 7

Showing significance of difference of Well Being scores of high and low resilience group (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High resilience	24	13.25	1.98	-1.08	1.645	.106	-2.40	.24
Low resilience	30	12.17	2.69					

Table 8 shows results of an independent sample t-test which was conducted to compare mean well being scores of subjects high on resilience and subjects low on resilience. The computed t-value is 1.645, which is not significant at 0.05. This indicates that mean difference is statistically non-significant. Since the t-value is statistically not significant further discussion for purposes of prediction is not required.

Our hypothesis **orthopaedically disabled subjects with high resilience will experience greater well being than orthopaedically disabled subjects with low resilience** is **rejected**.

Table 8

Showing significance of difference of well being scores of high and low parental acceptance groups (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High parental acceptance	20	13.45	2.064	-2.45	3.633	.001	-3.807	-1.093
Low parental acceptance	29	11.00	2.478					

Table 7 shows the results of an independent sample t-test which was conducted to compare mean well-being of a group of subjects which is high on parental acceptance and the group which is low on parental acceptance.

Results indicate that subjects who are high on parental acceptance have higher level of well-being as compared to subjects low on this dimension. The computed t-value is 3.633 which is significant at .05. This indicates that the mean difference of well-being between the two groups is statistically significant. The mean well being score of high parental acceptance group is 13.45 and mean well being score of low parental acceptance group is 11.00.

The mean difference between the two values i.e. –2.45 falls within the confidence limit at 95% (chances of mean difference falling between the values of –3.807 and –1.093 is 95%). Since the upper and the lower limit (-1.093 and –3.807 respectively) of mean difference are in the same direction, there are high chances that the same results will occur in the population also.

Our hypothesis – **orthopaedically disabled subjects high on parental acceptance with experience greater well-being than orthopaedically disabled subjects low on parental acceptance** is ***accepted.***

Table 9

Showing significance of difference of well being scores of male and female subjects (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
Male	50	12.52	2.61	1.12	2.363	.020	.18	2.06
Female	50	11.40	2.18					

Above table shows results of an independent sample t-test which was conducted to compare well being of male and female subjects. Results indicate that male subjects have high well-being as compared to female subjects. The computed t-value is 2.363 which is significant at .05. This indicates that the mean difference of well-being of male and female is statistically significant. The mean difference between the two values i.e. 1.12, falls within the confidence limit at 95% (chances of mean difference falling between the values of .18 and 2.06 is 95%). The direction of the upper limit (2.06) and the lower limit (.18) is the same direction, therefore similar results can be predicted for the population also.

Since the computed t-value is significant at .05, therefore, our hypothesis – **female orthopaedically disabled subjects will experience low well-being as compare to male orthopaedically disabled subjects** is *accepted.*

Table 10

Showing significance of difference of well being scores of high and low age groups (orthopaedically disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High Age	50	11.68	2.486	1.72	3.099	.003	.614	2.826
Low Age	25	13.40	1.732					

The above table shows the results of an independent sample t-test which was conducted to compare mean well-being of a high age group subjects and low age group subjects.

Results indicate that low age subject have high level of well-being than high age subjects. Computed t value is 3.099 which is significant at .05.

The mean difference between the two values i.e. 1.72 falls within the confidence limit at 95% (chances of mean difference falling between the values of .614 and 2.826 is 95%). We also observe that the lower and the upper limit (.614 and 2.826 respectively) are in the same direction, therefore there are high chances of seeing this trend in the population also.

In view of t-value being 3.099, our hypothesis – **orthopaedically disabled subjects falling in low age group and high age group will differ in well being** is ***accepted.*** This is a hypothesis of only difference and not direction. However, on perusing our results we find that, mean score of low well-being group is 13.40 and mean score of high well-being group is 11.68,

which means that well being of low age group is significantly higher than well being of high age group.

If we look at the results at a glance, we find that amongst the disabled, the factors of self efficacy, perception of social acceptability, optimism, parental acceptance together with age and gender were found to contribute to well being. Further, with regard four factors namely self-efficacy, parental acceptance, age and gender, there are high chances that phenomena will occur in the population also.

In order to understand if these factors are responsible for the occurrence of well being in the non-disabled also, analysis relating to non disabled sample was also conducted. This would enable us to understand the distinctive features in terms of factors responsible for well being among disabled and enlarge our understanding in this regard.

Table 11

Showing significance of difference of well being scores of high and low self-esteem groups (Non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High Self-esteem	31	15.42	2.277	-1.69	2.778	.007	-2.901	-.471
Low Self-esteem	30	13.73	2.463					

Table 11 shows results of an independent sample t-test which is conducted to compare mean well-being of group of subjects which is high on

self-esteem and the group which is low on self-esteem. Results indicate that subjects high on self-esteem have higher level of well-being as compared to subjects low on self-esteem. Computed t-value is 2.778 which is significant at .05. This indicates that mean difference is statistically significant. The mean difference between the two values i.e.–1.69 falls within the confidence limit at 95% (chances of mean difference falling between the values of –2.901 and -.471 is 95%). The lower and the upper limit (-2.901 and -.471 respectively) are in the same direction, similar trend can also be observed in the population.

The mean score of high self-esteem group is 15.42 and the mean score of low self esteem group is 12.59, therefore our hypothesis – **non-disabled subjects with high self-esteem will experience greater well-being than non-disabled subjects with low well-being** is ***ratified.***

Table 12

Showing significance of difference of well being scores of high and low self-efficacy groups (Non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High self-efficacy	47	15.11	2.556	-.86	1.293	.201	-2.179	.467
Low self-efficacy	20	14.25	2.291					

Table 12 shows results of an independent sample t-test which is conducted to compare mean well-being of group of non-disabled subjects which is high on self-efficacy and the group which is low on self-efficacy.

Computed t-value for mean difference is 1.293, which is not significant at .05. This indicates that mean difference is statistically non-significant. Since t-value is not significant the question of prediction in population does not arise.

Therefore our hypothesis – **non disabled subjects with high self-efficacy will experience greater well-being as compared to non-disabled subjects with low self-efficacy** is ***rejected.***

Table 13

Showing significance of difference of well being scores of high and low perseverance and tenacity groups (non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High perseverance & tenacity	29	15.55	2.324	-1.30	1.993	.052	-2.613	.009
Low perseverance & tenacity	24	14.25	2.418					

Above table shows results of an independent sample t-test which is conducted to compare mean well-being of non-disabled group which is high on perseverance and tenacity and the group which is low on perseverance and tenacity.

Results indicate that subjects high on perseverance and tenacity have high level of well-being as compared to subjects how on this dimension. Computed t-value is –1.993 which in a one-tailed test is significant at .05 level. This indicates that mean difference is statistically significant.

The mean difference between the two values, i.e. –1.30, falls within the confidence limit at 95%. The upper limit (.009) and the lower limit (-2.613) are in the different directions, this is not a dependable value for the prediction of the population.

However, our hypothesis that **non-disabled subjects with high perseverance and tenacity will experience greater well-being than non-disabled subjects and low on perseverance and tenacity** is *accepted.*

Table 14

Showing significance of difference of well being scores of high and low perception of social acceptability groups (non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High perception of social acceptability	44	14.57	2.405	.08	.142	.887	-1.095	1.263
Low perception of social acceptability	23	14.65	2.058					

The above table shows results of an independent sample t-test which is conducted to compare mean well being of group of non-disabled subjects which is high on perception of social acceptability and the group which is low on perception of social acceptability.

Results indicate that computed t value is .142 which is not significant at .05. That is the mean difference is statistically non-significant. Thus the aspect of prediction in population does not arise and need not be studied.

Our hypothesis **non-disabled subjects with high perception of social acceptability experience greater well-being as compared to non-disabled subjects low on perception of social acceptability** is ***rejected.***

Table 15

Showing significance of difference of well being scores of high and low optimism groups (non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High optimism	28	15.14	2.103	-.92	1.492	.141	-2.148	.314
Low optimism	31	14.23	2.565					

The above table shows the results of an independent sample t-test which was conducted to compare mean well-being of a group of non-disabled subjects high on optimism and group of non-disabled subjects low on optimism.

Results indicate that non-disabled subjects high on optimism have an insignificant high score on well-being as compared to subjects low on this dimension. Computed t-value for the mean difference is 1.492 which is not significant at .05 level. This indicates that mean difference is statistically non-significant. The mean difference between the two values is -.92 falls within the confidence limit at 95% (chances of mean difference falling between the values

of –2.148 and .314 is 95%). However since t-value is insignificant, this need not be further discussed.

We may conclude that our hypothesis **non-disabled subjects with high optimism will have greater well-being than non-disabled subjects low on optimism,** is ***rejected.***

Table 16

Showing significance of difference of well being scores of high and low spirituality groups (non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High spirituality	30	15.70	2.351	-1.00	1.665	.102	-2.196	.203
Low spirituality	27	14.70	2.145					

Above table shows the results of an independent sample t-test which was conducted to compare mean well-being of a group of non-disabled subjects which is high on spirituality and the group which is low on spirituality. Computed t-value is 1.665 which is not significant at .05 level. This indicates that mean difference is statistically non-significant. The mean difference between the two values i.e. –1.00, falls within the confidence limit at 95% (chances of mean difference falling between the values of –2.196 and .203 is 95%). However this aspect need not be discussed in view of non-significant t-value.

Since the computed t-value is insignificant, our hypothesis, **non-disabled subjects with high spirituality experience greater well-being than non-disabled subjects with low spirituality,** is ***rejected.***

Table 17

Showing significance of difference of well being scores of high and low resilience subjects (non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High resilience	34	15.76	2.203	-.162	2.891	.005	-2.735	-.498
Low resilience	27	14.15	2.215					

The above table shows results of an independent sample t-test which is conducted to compare mean well-being of group of non-disabled subjects with high resilience and group of subjects with low resilience.

Results indicate that subjects high on resilience have higher levels of well being than subjects low on resilience. The computed t-value for the mean difference is 2.891, which is significant at .05. This shows that mean difference is statistically significant. The mean difference between the two values i.e. -.162 falls within the confidence limit at 95% (chances of mean difference falling between the values of –2.735 and -.498 is .95%).

The mean confidence interval in the above table is in the same direction, i.e. the lower limit (-2.735) and the upper limit (-.498) have some directions, there is high probability of seeing the same trend in the population.

Our hypothesis **non-disabled subjects with high resilience experience greater well-being than non-disabled subjects with low resilience,** is ***accepted.***

Table 18

Showing significance of difference of well being scores of high and low parental acceptance groups (non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High parental acceptance	31	15.06	2.337	-1.47	2.087	.042	-2.891	-.056
Low parental acceptance	22	13.59	2.789					

Table 17 shows results of an independent sample t-test which is conducted to compare mean well-being of group of non-disabled subjects which is high on parental acceptance and non-disabled subjects low on parental acceptance.

Results show subjects high on parental acceptance experience higher level of well-being than subjects low on parental acceptance. The computed *t*-value is 2.087, which is significant at .05. This indicates that mean difference is statistically significant. The mean difference between the two values i.e. –1.47,

falls within the confidence limit at 95% (chance of mean difference falling between the values of –2.891 and -.056 is 95%). If we look at the upper limit (-2.891) and lower limit (-.056) of the 95% confidence interval. We find that they are in the same direction. This indicates that there are strong chances that the same trends can be observed in the population also.

The mean score of high parental acceptance group, on well-being is 15.06 and the mean of low parental acceptance group on well-being is 13.59.

Therefore, our hypothesis **non-disabled subjects with high parental acceptance experience greater well-being than non-disabled subjects with low parental acceptance** is ***accepted.***

Table 19

Showing significance of difference of well being scores of male and female subjects (non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
Male	50	14.96	2.38	.38	-.59	1.35	.774	.441
Female	50	14.58	2.52					

Above table shows results of an independent t-test which is conducted to compare mean well-being of male and female non-disabled subjects.

Results indicate that computed t-value for the mean difference is .59 which is not significant at .05. This indicates that mean difference is statistically non-significant. Therefore, our hypothesis **female non disabled**

subjects experience low well-being than male non-disabled subject is ***rejected.***

Table 20

Showing significance of difference of well being scores of high and low age groups (non-disabled)

Groups	N	Mean well-being scores	S.D.	Mean difference	t	p	95% of confidence interval of the mean difference	
							Lower limit	Upper limit
High age	35	14.60	2.725	.40	.696	.488	-.744	1.544
Low age	42	15.00	2.316					

Above table shows results of an independent sample t-test which is conducted to compare mean well-being high age and low age non-disabled subjects.

Results show that high age subjects have slightly high levels of well-being than low age subjects. The computed t-value for the mean difference is .696 which is not significant at .05. This indicates that mean difference is statistically non-significant. The mean difference between the two values, i.e. .40, falls within the confidence limit at 95% (chances of mean difference falling between the values of -.744 and 1.544 is 95%). However, since t-value is insignificant there is no need to study the aspect of prediction.

Our hypothesis, **non-disabled subjects falling in higher age group will differ from non-disabled subjects falling in low age group** is ***rejected.***

Thus, we find that our hypothesis, regarding, self-efficacy, perception of social acceptability and optimism amongst the orthopaedically disabled have been supported by our results.

Chapter V

DISCUSSION

The results obtained by the researcher have been reported in the preceding chapters. Interpreting and discussing the results realistically within the framework that interrelates all the information obtained, so as to help to present an integrated picture of the phenomena being studied is an important responsibility of the researcher. It is in this light that results obtained are being discussed.

The major objective of the research was to study which factors under study contribute to well-being amongst the disabled. Resilience, parental acceptance, gender and age were factors selected for study. Resilience was studied both as a single composite factor and also in terms of six component factors, namely self-esteem, self efficacy, perseverance and tenacity, perception of social acceptability, optimism and spirituality. Some very interesting information emerged in this regard. First, resilience as a composite factor was not found to contribute to well being amongst the orthopaedically disabled. Disabled subjects high on resilience and low on resilience did not differ on their mean scores on resilience. This is in contradiction to findings obtained by various researchers. Christopher (2000) observed that higher resilience is one of the strongest predictors of psychological well-being. Turner (2001) opines that resilience is the quality which enables individuals to live functional lives with a sense of well being even in the face of adversity. Werner & Emny (1995) found that resilient children not only possess good interpersonal skills but have faith in their own actions which impacts positively on their quality of life. Qualities of resilience and hardiness enable subjects to perceive life events more positively (Nathawat & Joshi, 1997). This positive perception endows individuals with a more positive world view and feelings of subjective well-being.

In the non-disabled sample, our findings are in conformity with empirical findings. Not only were those high on resilience significantly better on well-being than those low on resilience, even in terms of mean difference and analyses in terms of 95% confidence interval of mean difference, values obtained indicated that these conclusions could dependably predict the phenomenon in the population also. A more explanatory and clear picture will be forthcoming after the status of contributions to well-being of each of the component factors of resilience is discussed both in disabled and non-disabled group.

It is observed, that three component factors of resilience are contributing significantly to the experience of well-being amongst the disabled. Self-efficacy, perception of social acceptability and optimism were found important factors in this regards. Disabled subjects high on self-efficacy, perception of social acceptability and optimism were experiencing significantly greater sense of well being than subjects low on these variables.

A finding of great interest is that self-esteem was **not** found to exercise influence on well-being amongst the orthopaedically disabled.

The role of self-esteem has been emphasized by positive psychologists and empirical findings identify it as one of the most important factors leading to sense of well being. According to De Neve and Cooper (1998), self-esteem is one of the traits most closely related to subjective well-being. Greenier, Kernis, McNarmara, Waschul et al. (1999), pointed out that individuals with high and stable self-esteem were able to withstand the impact of negative events, which indicates that they are in a position to experience greater sense of well-being. Yarkeski, Mohan and Yarkeski (2003) found a high correlation

between self-esteem and positive health practices, which is an indicator of subjective well being. DiPaula and Campbell (2002) observed that high self-esteem groups have ability to be more persistent across goals and are more effective in self-regulating goal directed behaviours. They possess qualities which outcome in sense of well-being. A vast plethora of studies point to the role of self esteem in creating positive feelings.

Self esteem may be briefly defined as the degree to which the self is perceived positively or negatively i.e. one's overall attitude towards the self. It appears that for the disabled, this self perception of positivity was not related to well being. However self-efficacy was found to have a significant contribution. Self efficacy refers to beliefs about capabilities to produce designated levels of performance that exercise influence over events that affect one's life. A strong sense of efficacy enhances human accomplishment and personal well being in many ways (Bandura, 1986). For the disabled group, actual reaching of desired goals appears to be of greater value than self esteem for experiencing well being. Achieving targets and objectives essential to live decently and successfully are more difficult for disabled because their deficits demand extra efforts. Feelings of self efficacy reflect a sense of achievement and victory in spite of unfavourable odds. Rather than positive estimate of the self (self-esteem), the successful attainment of targets spells feelings of greater well being for the disabled.

It is interesting to note that in the non-disabled sample, self-esteem contributed very significantly to sense of well being. This is in conformity with the theoretical picture and empirical findings. On the other hand, in the non-disabled group, self-efficacy was not a significant predictor. This finding does

not conform to the picture given by empirical data available. It is difficult to account for such a divergent finding. One possible explanation which comes to the mind of the researcher is that well being is an extremely broad concept. We have adopted the approach of studying well being as being represented by the level to which people show positive sentiment and positive attitude towards various aspects of their lives. Understandably, there are diverse psychological indicators of well-being. Kozma and Stones (1978) advocated that instead of taking well-being as an overall concept and combining dimensions into an overall index, separate dimensions be kept for analysis. Perhaps this procedure is more desirable and would yield better results.

Perception of social acceptability is another factor that was found to contribute to feelings of well-being in the orthopaedically disabled sample. Our sample consisted of orthopaedically disabled persons. The physical self is an important aspect of an individual's self image, therefore being one with the normal group is something which affords great happiness. Usually disabilities and deformities may elicit sympathy but this may be perceived as a condescension rather than real acceptance and inclusion. Being genuinely accepted within the group is a factor, which has a very special meaning for the disabled. Therefore, those perceiving themselves as socially accepted experience greater well being than those low on perception of social acceptance. Considering the fact that the orthopaedically disabled cannot participate in many social and extra curricular activities which young people usually engage in, acceptance and inclusion in the group is a matter of supreme importance. This social acceptance strengthens the perception of social support which is placed by Health psychologists at a very focal position as a factor contributing to mental health and well being. According to Margalit (2003),

reciprocity in relation with both adults and peers plays a critical role in providing an inner source of energy for the individual. Its role in alleviating severe traumatic situations even those associated with cancer and HIV has been strongly underlined. For the disabled group also, the sense of social support, which perception of social acceptability in all likelihood affords them, makes an important contribution to well being.

For the non-disabled this perception of social acceptability does not have the same type of significance. It is something that comes almost in the normal course, therefore, it may not be evaluated by this group as being a contributor of well-being. This does not means that perception of social acceptability is not important for the non-disabled. It may be impacting positively upon other dimensions of their lives, but on subjective well-being it's contribution was not seen in the sample.

The third factor which was found a significant contributor to well-being amongst the orthopaedically disabled was optimism. It is an attitude towards life which prevents people from becoming apathetic and giving up hope. Optimism may be defined as a generalized expectancy that one will experience good outcomes in life (Scheier and Carver, 1985). Scheir and Carver (1992) further go on to say that optimism is a disposition to believe in favourable rather than unfavourable outcomes to problems and is the most powerful predictor of positive behaviour.

For the disabled, the future in today's competitive world is not very promising and bright. It is difficult to contemplate a life of self-sufficiency with normal systems like marriage and family in the same manner that normal non-disabled people can contemplate. Optimism and hope thus become an

important quality for the disabled. Those who possess this quality are manifesting the will to transcend odds that may occur and have high hopes for the future. This positive quality endows them with the experience of well-being.

It may noticed that further statistical analyses has revealed that though this phenomena is found in the sample, this conclusion cannot be dependably applied to the population. Therefore, there is a limited applicability of this finding.

In the non-disabled subjects, optimism did not appear as a significant contributor. Explanations in this regard may be sought on lines similar to what was discussed with regard to social acceptability. However, it must be accepted that the finding is very contradictory to the theory of resilience and experimental findings in this regard.

Another factor which has been conceptualized to be related to well-being is spirituality. Both in the orthopaedically disabled and the non-disabled group spirituality does not contribute to well-being. Although, it was observed by the researcher that both the disabled and the non-disabled group have a strong belief that there exist some force or superpower which helps people in their adversities or difficult to times. However, this phenomena did not appear to be a significant predictor of well-being, in the study. The finding should be evaluated in the light of the fact that the subjects in our study were relatively young. Compared to the other concepts studied by the researcher, the phenomenon of spirituality can be understood and becomes more clear at a relatively higher age. For Jung, it is during middle age that spirituality becomes a predominant factor. This statement reflects an important Jungian principle,

but since we are not talking of spirituality as a key personality factor which moves people's lives, we were well within reason to expect that even in the age group studied, it would be seen as a contributor to positive quality of life. Spirituality has been found to correlate positively with general health status, psychological well being and social support (Latha and Yuvaraj, 2006). Kennedy and Kanthamani (1995), found that people who have paranormal and transcendent/spiritual experiences, reported that these experiences increased their sense of well-being. However, in our study this finding was not endorsed because this metaphysical concept was perhaps not fully in the grasp of our subjects.

With regard to resilience and its factor we can now take stock of our findings. Amongst the disabled three component factors, namely self efficacy, perception of social acceptability and optimism were found significant contributors to well-being. The contribution of self-efficacy was predicted in the population also. However, resilience as a single factor did not emerge to be a significant contributor. It is strongly felt that resilience should be taken as a broad concept with significant implications for positive psychology but it should be appreciated that the various factors which comprise it should individually be the focus of researcher. Individuals who possess overall ability to face adversities may not have each and every quality that comes under the umbrella of resilience, the combination may be different for people under different situations.

The diversities and uniqueness in the human being do not permit very broad concepts to be defining factors. This was one of the arguments in the trait vs type approach. Without entering into any controversy of that nature, it is the

submission of the researcher, particularly on the basis of the present findings, that rather than study resilience in totality as a single concept, it is more meaningful to study its components.

Parental acceptance emerged as a significant predictor of well being for orthopaedically disabled as well as non-disabled groups and for both the groups, the further analysis of mean difference revealed that the phenomena would be found in the population also.

Parents perhaps are the basic source through whom child is initiated to the experience of well-being. The accepting behaviour of parents gives a child warmth affection, approval, security and understanding. The concept of parental acceptance implies that the child is accepted physically, mentally, emotionally and psychologically by his/her parents. A child needs a reasonable degree of acceptance in order to lead a healthy happy and a decent life (Kelly and Wallestrain, 1976).

This is borne out by a large number of empirical findings. Parental acceptance helps children in acquiring qualities which are highly related to well-being. According to Symonds (1939) children accepted by parents are more co-operative, socialized, friendly have highly valued characteristics and are happier and stable, than the rejected group of children. According to Jain (1998) children with high parental acceptance are more emotionally stable, less on timidity, apprehensiveness and tenseness and have generally a greater sense of well being than those with low parental acceptance. DeMinzi and Maria (2006) found that acceptance of parents promoted secure attachments and positive outcomes in children. Powers and Witmer (1974), Kelly and

Wallerstan (1976) also emphasize the importance of parental acceptance on the basis of their empirical findings.

Gender and age were two other factors that were studied. Amongst the orthopaedically disabled group a difference was seen in males and females with regard to well being. Women were significantly lower on well being than men, analyses of mean differences indicating that this could be the direction in the population also. Gender thus emerged as a significant predictor of well being amongst the disabled. Interestingly in the non-disabled sample no difference was observed amongst males and females in well being scores. Thus, while gender was a significant predictor of well being in disabled subjects it was not so amongst the non-disabled.

Gender is a reality, not merely in terms of sex differences, of being male and female but in terms of experiences to which one is exposed to, the societal expectations, roles, and prejudices which exist. With awareness and social change together with education and increasing self sufficiency among females, some degree of levelling out has definitely taken place in the Indian society. Education is one of the key factors in this. Agencies like the UGC give impetus to women's education by providing special scholarships. Recently a scholarship of high financial value was announced by UGC for all girl students who were the only child of their parents and were undergoing higher education. Other agencies are not behind in giving active help for women's education and also creating awareness. Perhaps as a consequence of these ventures no gender differences in well-being appeared in the total sample.

For the disabled the picture is different. Definitely the orthopaedically disabled girls constitute a group that experiences many major problems. Some

occupational avenues have been opened and such women are getting a priority in some spheres But looking at the pattern of society as it exists today, a disabled male may be able to find a life partner and have a relatively normal family life, but a disabled female is not usually chosen as a life partner at least by a person with whom she could live with dignity. The disturbed and bleak picture of the future is one big problem Her present also is like to be more difficult than the disabled male's. The family atmosphere and attitude of society may also be very disturbing for her. Therefore, it is not surprising that in terms of well-being, she is lesser than her male counterpart. Carmel, Bernstein (2003) indicate that in nearly both genders if comparison is made by age, women score lower than men on indicators of physical and psychosocial well-being.

Again it was only for the disabled group that the factor of age had some contribution for well being. The low age group manifested a higher sense of well being than the higher age group. Further analyses of mean difference indicated that this phenomena would be seen in the population also. This clearly indicates that with the passage of time, the disabled person experiences less well being. Coping with the problem takes a toll on his resources and affects him to some extent. Other positive factors in personality may help him out and in the overall sense he/she may be coping, but increasing age does not contribute to well-being.

The relationship between subjective well-being and age was studied by James (1995) in two studies, the first a cross-sectional design with over 1000 participants which revealed a positive association between well-being and age, age being the most significant predictor of well being amongst all studies. The

second was a longitudinal study in which it was found that well being had become less later as compared to its status in the beginning of the study. In a way, this is observed in our findings also. Morris (2006) investigated whether perceived changes in one's well being from the present to the future are related to chronological age. One way manova showed that there were chronological age differences in the magnitude of future self enhancement effects of well-being. Further self enhancement were large for young adults than for middle age adults.

Undoubtedly well-being is one of the most important goals which all of us strive for. We now have a picture of factors which contribute to experience of well-being amongst the disabled group. Personal resources as well as the role of significant others has been highlighted. Some of the factors that we had felt, on the basis of earlier studies, to be highly significant in terms of their possible contribution, did not emerged as significant. This is not surprising, because human nature is a complex phenomena and we should not expect it to fall into totally predictable slots. Furthermore all individuals researches suffer from serious limitations, even though at the stage of inception they are planned taking into consideration all possible aspects that come to the mind. Every work which is planned has some protocols, which one cannot interrupt in between. Major changes cannot be made in between. However, every research that is conducted with honesty and sincerity does yield valuable information and the present research falls in this category. As such we find certain factors which comprise resilience to be of great significance, namely self-efficacy, perception of social acceptability and optimism that emerged. Since resilience is comprised of both certain characteristics which are native to the individual but a greater degree it is a capacity that can definitely be developed. Therefore

through proper interventions and experiences, efforts can be made to promote and nurture these qualities in disabled persons. This will help them to achieve well-being and happiness.

The role of parents emerged of supreme importance. Although parents have a natural love for their offsprings yet some non-deliberate acts of omission and commission may disturb and demoralize the child, parents need to understand this, particularly with regard to disabled child. The disabled girl needs to be treated with great empathy and understanding and disabled children as they grow older need to be attended because together with problems arising out of their disability, problems associated with puberty and adolescence compound their stress, leading to lowered well-being. This aspect needs to be taken cognizance of.

Many doubts an querries have emerged out of the research. This is a very important contribution of any research because in the ultimate analysis, scientific research is a joint venture in which subsequent researchers take up from where an earlier researcher left. Gradually the phenomena becomes more and more clearly understood and applications emerging out of the research can be implemented to contribute to society.

We have studied 'parental acceptance' as one of the determinants of well-being amongst the disabled. Researches in the area of parenting practices reveal that fathers and mothers influence their offspring's psychological development in different ways. Therefore, further researchers should focus on studying separate influences of each of the parents separately on well-being.

A correlational design helps to explore the nature and dynamics of relationships within the studied variables. Going further on these lines, one

should try to explain the role of each correlate on well-being following an advanced (preferably multivariate) model.

Disabled children come from different socio-economic strata, cultural background and these backgrounds may be influencing their well-being. In order to study the impact thoroughly, one should follow a cross-sectional design. Since age is also mediating in the phenomena one can study its impacts in a more realistic manner by using a longitudinal design.

Efforts should be made to identify maximum number of factors that account for variance in well-being subsequently. The amount of variance by each variable may be explained.

Creating awareness, about the disabled, is another responsibility of the people working in the area of disability. The handicapped individual is a part of society and must function in the mainstream (Sen, 1988). Assessing the potentialities of the disabled, and giving vocational training in accordance with the disability must be the goal of the psychologists, counsellors.

Power (2003) offers advice and hope for families with a child who has serious illness or disability. The resilient family knows how to identify the strengths that already exist in the family and then use the strengths to enable the family to flourish men in the face of burdens that feel unbearable.

Psychologists, researchers should work on resilience enhancing, intervention programs for the disabled. Hughes, Robinson-Whelen, Taylor and Swedlund (2004).

Schools both public and private should open their avenues for the disabled since orthopaedically disabled does not usually have intellectual

deficits, schools merely need to provide facilities which are necessary for mobility and comfort of such children. These facilities are mandatory, but most schools ignore this directive. Even for other types of disabilities, like Learning Disabilities, schools need to take cognizance and provide special education provisions etc. so that challenged children are able to come into the mainstream. This will help the disabled and the non disabled to develop a sense of working together with an attitude of caring and sharing. This is the spirit of Integrated Education.

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APPENDICES

PERSONAL DATA SHEET

Name	:		
Age	:		
Sex	:		
Father's Name	:		
Age	:		
Educational Status	:		
Occupation	:		
Mother's Age	:		
Age	:		
Educational Status	:		
Occupation	:		
Number of Brothers	:	Sisters :	
Family System	:	Nuclear	Joint
Hobbies			

Appendix I

PGI WELL BEING SCALE

Instruction : How do you feel these days (Past one month) ? Kindly tick (√) the items applicable to you.

1.	In good spirits.	( )
2.	In firm control of behaviour and feelings.	( )
3.	Fairly happy in personal life.	( )
4.	Sleeping fairly well.	( )
5.	Interested in life a good bit of the time.	( )
6.	Feeling emotionally stable a good bit of time.	( )
7.	Feeling relaxed most of the time.	( )
8.	Feeling energetic most of the time.	( )
9.	Feeling cheerful most of the time.	( )
10.	Not bothered by nervousness.	( )
11.	Not bothered by anxiety or worry.	( )
12.	Not easily tired.	( )
13.	Not bothered by illness or pain.	( )
14.	Not feeling depressed or dejected.	( )
15.	Feeling satisfied with life in general.	( )
16.	Not easily irritated most of time.	( )
17.	Feeling useful, wanted.	( )
18.	Feeling productive, creative.	( )
19.	Having a sense of belongingness.	( )
20.	Being in good health.	( )

Appendix - II

RESILIENCE SCALE

Please read each statement carefully. Against each statement, four possible answers are given. If you feel that a statement applies to your always; tick mark against 'always' if it is often true for you, tick-mark against 'often'; if it is sometimes true for you tick mark against 'sometimes' and if it is never true for you tick-mark against 'never'. Please take your time and indicate yow you really feel.

		Always	Often	Sometimes	Never
1.	I think that I have my own unique strengths.	( )	( )	( )	( )
2.	I think that the existence of the soul is as real as physical existence.	( )	( )	( )	( )
3.	I find that I continue to work for a task even if other don't support me.	( )	( )	( )	( )
4.	I believe that human existence has a definite purpose.	( )	( )	( )	( )
5.	I set goals for myself and work in appropriate direction.	( )	( )	( )	( )
6.	I believe that everything in this life has meaning.	( )	( )	( )	( )
7.	I think that I possess qualities, which people respect.	( )	( )	( )	( )
8.	I feel convinced that good ultimately predominates over evil.	( )	( )	( )	( )
9.	I feel happy that I am a good human being.	( )	( )	( )	( )
10.	I believe that all the pain that we undergo will ultimately be rewarded.	( )	( )	( )	( )
11.	I find that when I decide to do something I continue my efforts till I succeed.	( )	( )	( )	( )
12.	I believe that I will definitely get what I want.	( )	( )	( )	( )
13.	I think that just like other persons I have my own short comings	( )	( )	( )	( )
14.	I believe that the Supreme Power is just and Merciful.	( )	( )	( )	( )

15.	I believe that after a problem there will be favourable outcome.	( )	( )	( )	( )
16.	I think I am better than many people in many things.	( )	( )	( )	( )
17.	I believe that overall I have an attractive personality.	( )	( )	( )	( )
18.	I find that there are many areas in which I perform excellent.	( )	( )	( )	( )
19.	I find that I am fond of challenging tasks.	( )	( )	( )	( )
20.	When I undertake an assignment, I feel that I will succeed.	( )	( )	( )	( )
21.	I believe that if we make efforts, the world can be come a beautiful place.	( )	( )	( )	( )
22.	I believe that no circumstances can stop my enthusiasm for long.	( )	( )	( )	( )
23.	I believe that every person has an element of divine within him/herself.	( )	( )	( )	( )
24.	I find that I attempt tough question first.	( )	( )	( )	( )
25.	I feel that I am easy making friend.	( )	( )	( )	( )
26.	I believe that what others can do I can do better.	( )	( )	( )	( )
27.	I feel that I am inspired from within.	( )	( )	( )	( )
28.	I feel that my family feels proud me.	( )	( )	( )	( )
29.	I believe that the future has many positive things in store.	( )	( )	( )	( )
30.	I have many hopes and desires in life.	( )	( )	( )	( )
31.	I feel that I do not hesitate to undertake an assignment, which others avoid because of it being tough.	( )	( )	( )	( )
32.	I believe that I regard myself as a capable person.	( )	( )	( )	( )

33.	I find that I have a large number of friends.	( )	( )	( )	( )
34.	I think that I am not the kind of person who runs away from difficult situations.	( )	( )	( )	( )
35.	I believe that if I don't perform well, I think of new ways of doing the work.	( )	( )	( )	( )
36.	I believe that the future is bright for me.	( )	( )	( )	( )
37.	I feel that my desires will be fulfilled.	( )	( )	( )	( )
38.	I find that my friends take my help in many ways.	( )	( )	( )	( )
39.	I feel that my parents feel proud of me.	( )	( )	( )	( )
40.	I feel challenging tasks exciting.	( )	( )	( )	( )
41.	I feel that it is more important to do what is right, that to worry about loss and gain.	( )	( )	( )	( )
42.	I feel happy at the end of the day.	( )	( )	( )	( )
43.	I believe that it is worthwhile to suffer for spiritual truth.	( )	( )	( )	( )
44.	I feel my peers are fond of me.				

Appendix- III

PARENTAL ACCEPTANCE SCALE

Please read each statement carefully. The statements show relationship between parents and their children. If you think that your parents always behave in the same manner, put the tick-mark against always; if you think your parents often behave in this way, put the tick-mark against 'often'; if you think your parents sometimes; treat you in that manner, put the tick mark against sometimes; and if think your parents never treat you in that manner, put the tick-mark against never.

I would like to assure you that your answers will be kept secret and no one expect me will come to know them.

		Always	Often	Sometimes	Never
1.	My parents are friendly towards me.	( )	( )	( )	( )
2.	My parents help in solving my problems.	( )	( )	( )	( )
3.	My parents spend sometime to play with me.	( )	( )	( )	( )
4.	My parents go for a walk with me.	( )	( )	( )	( )
5.	My parents help me in my school work.	( )	( )	( )	( )
6.	My parents allow me to speak freely with them.	( )	( )	( )	( )
7.	Love of parents spoils children.	( )	( )	( )	( )
8.	My parents are careful about my feeling.	( )	( )	( )	( )
9.	I feel quite free in my home.	( )	( )	( )	( )
10.	My parents allow me to invite my friends at home.	( )	( )	( )	( )
11.	I like to work according to the wishes of my parents.	( )	( )	( )	( )
12.	My parents punish me in order to maintain discipline.	( )	( )	( )	( )
13.	My parents provide things for recreation of my friends.	( )	( )	( )	( )
14.	My parents participate in my interests.	( )	( )	( )	( )

15.	My parents criticize my friends for my benefits.	( )	( )	( )	( )
16.	My parents do not think much of my abilities.	( )	( )	( )	( )
17.	My parents treat me as a responsible person.	( )	( )	( )	( )
18.	My parents find lack of some good characteristic in me.	( )	( )	( )	( )
19.	My parents give very little importance to my ideas.	( )	( )	( )	( )
20.	My parents do not care whether I have friends or not.	( )	( )	( )	( )
21.	I consider my parents to my friends.	( )	( )	( )	( )
22.	My parents are interested in all those things, which concern me.	( )	( )	( )	( )
23.	My parents think about my well being.	( )	( )	( )	( )
24.	My parents express their love for me.	( )	( )	( )	( )
25.	My parents feel happy to spend their time with me.	( )	( )	( )	( )
26.	My parents are friendly and affectionate towards me.	( )	( )	( )	( )
27.	My parents are interested in looking after me.	( )	( )	( )	( )
28.	My parents are very considerate towards me.	( )	( )	( )	( )
29.	My parents love me very much.	( )	( )	( )	( )